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The Highest Possible Level

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MANY CENTURIES AGO the Roman philosopher, Marcus Aurelius Antoninus, wrote: "My city and my country, so far as I am Antoninus, is Rome, but so far as I am a man, it is the world." Thus, so long ago, he anticipated the situation in which we find ourselves today. As Canadians we are proud of our birthright, our country, our progress in so many directions. Being loyal Canadians, however, does not in any way impair our interest in and our concern about world affairs. As Canadian nurses we are particularly affected by what is being undertaken to offset the ravages of disease on a world-wide basis. Thus, we should all be aware of the purpose and activities of the body that is chiefly concerned with the vast program that is now in its third year under the World Health Organization.

Created on September 1, 1948, WHO's world-embracing objective was agreed to be "the attainment by all peoples of the highest possible level of health." With the receipt of the instruments of ratification of the WHO constitution from Nicaragua, the number of countries that are currently members stands at 69. Of that number, unfortunately, seven have notified WHO of their withdrawal from active participation.

Though Geneva, Switzerland, is the site of the headquarters of WHO, regional offices are or will be established in many quarters of the globe.

Six fields of study and endeavor have been given top priority. In the van is *malaria* that annually strikes an estimated 300,000,000 persons, of whom about 1 per cent die. Others are so badly weakened that their productivity as agricultural workers is greatly reduced.

In this field it is easy to demonstrate that money spent on health is a sound investment. Thousands of acres of good land are depopulated or under-cultivated because of malaria. Its control is now a practical and economical possibility, thanks to DDT and other means; but an effective organization and trained personnel are essential for the success of the whole program.

An estimated 50,000,000 people fall prey to *tuberculosis* each year, with some 5,000,000 deaths. WHO has made surveys in a large number of

countries. The International Tuberculosis Campaign, providing B.C.G. vaccination for children and young adults, has already reached the phenomenal figure of 10,000,000 vaccinations in the European countries. This campaign is now being extended to the Eastern Mediterranean, North Africa, Asia, and the Americas.

WHO is seeking to reduce, through modern treatment, the high post-war rate of the *venereal diseases*. An estimated 2,000,000 deaths yearly are attributed to syphilis. Demonstration teams are already at work in conjunction with UNICEF, to promote programs of rapid penicillin treatment.

The other three top priority services include *Sanitation*, *Maternal and Child Health*, and *Nutrition*. Requests from member governments for technical assistance far outstrip WHO's present capacity to provide these services, not to mention the very considerable demands made in related fields. For example, a mental health expert has been requested to deal with the *narcotics* situation in the Eastern Mediterranean area. *International standards* have now been fixed for 38 biological products, such as penicillin, streptomycin, vitamins, B.C.G., etc. Uniform names and dosages have been established for a variety of chemical drugs. The first *International Pharmacopeia*—produced by WHO—will be published this year.

Emergency aid of many kinds is also supplied by WHO. Providing for the delivery, by aircraft, of iron lungs to combat the ravages of polio; rushing medical supplies to prevent or control epidemics of typhoid, of cholera, of smallpox are but a few of the miracles this health-motivated organization performs.

To nurses bound by the four walls of a hospital, or striving to interest her small community in establishing a child health centre, or busily assisting a physician in the local immunization clinic, WHO's accomplishments seem very far away, dramatic, and somewhat unreal. Yet each nurse, as she goes about her daily tasks, is a part of the grand program of helping people everywhere to reach the "highest possible level of health." It is an inspiring thought!

Correct Procedure in a Toast

When proposing a Toast to the King, the chairman rises, brings the audience to attention, and asks them to rise and drink a toast to His Majesty. At this, the audience rises. The chairman says, "Ladies and Gentlemen, 'The King.'" Then, and only then, is the glass lifted from the table, held at eye level for a moment, one sip of liquid is taken and the two words "The King" repeated *before* the glass is replaced on the table. No other procedure is correct for a civilian pledging the health of His Majesty. *Glasses are never clinked.* Guests must not smoke before this toast has been proposed. It is *not* correct to play or sing the National Anthem when a Toast to His Majesty is proposed.

Plural Births

The likelihood that a confinement will result in a multiple birth depends upon various factors. Age of the mother is one of them. The frequency of plural births increases progressively with advance in age of mother to a maximum at ages 35-39 and then falls off somewhat. The chances are better than 17 in 1,000 that the confinement of a woman in her late 30's will yield a plural birth. For teenage mothers, the chances are only 6 in 1,000.

—M.L.I.C. Statistical Bulletin

Using the Refrigerator

Once, a refrigerator was merely a place to store foods. Now, wise homemakers use it as a kitchen helper—to make meal-planning easier and, in summer, cooler. You've no idea what exciting dishes can come out of it—mousses, cheese-rings embellished with summer-fresh fruits; sherbets with novel trimmings, a regal meat-loaf decked with stewed fruit. Meals like these can be prepared hours ahead and stored till serving time. Baked dishes can then be heated before serving.

Chronic Arthritis

HAROLD ROBINSON, M.D.

Average reading time — 18 min. 24 sec.

ARTHRITIS, or rheumatism, as it is known to the lay public, is not a new condition. It was common in ancient populations. It has been found in the skeletons of neolithic cave-men and was a frequent ailment among the pre-dynastic natives of Egypt and Nubia. Spondylitis deformans, for example, was common among Egyptians as long ago as 2900 B.C. and, in one known case, as long ago as 5000 B.C. Rheumatic changes have also been found in the remains of prehistoric man, in neolithic graves in France, and in skeletons from Pompeii. Before the age of man, such animals as the extinct sabre-toothed cat of one-half million years ago, the dinosaurs and crocodiles of the lower Miocene period suffered from arthritis.

The general distinction of chronic arthritis from gout was delayed until the end of the 18th century, when an attempt was made to differentiate certain forms of rheumatism. Until recent times, the spas and watering-places, popularized by the Romans on the continent and in England, provided the only relief to sufferers of these conditions. The interest of the medical profession as a whole was stimulated by investigators who began to point out the great incidence of disability and loss of work occasioned by these conditions. At the same time it became evident that people suffering from arthritis, and not getting help from medical men, were turning to irregular practitioners, who were only too happy to lend their doubtful services. To manufacturers of patent medicine this proved a most lucrative field. As late as 1941, Dr. Hench of the Mayo Clinic reported some 550 remedies offered for the relief and cure of rheumatism.

The Empire Rheumatism Council, formed in England in 1937, exposed a large number of "cures" for arthritis unloaded on the public. These varied from electric belts to apples. The electric belts presumably sent uninterrupted electrical impulses through the body and ostensibly one's rheumatism vanished. Actually, they were coated with an irritating chemical substance. The apples were from a special orchard and were of great efficacy in the treatment of these conditions. They could be procured at a price. These are only two samples picked at random from hundreds of like "cures."

The air of confusion about rheumatic diseases began to clear somewhat about 25 or 30 years ago. Rheumatic associations have since been set up in the larger countries—England, the United States, and the Continent and, more recently, in Canada. The whole field was re-evaluated in the light of modern knowledge and new, more adequate classifications were made. An International League against rheumatic disease has also been set up and delegates from all countries attend conventions and exchange knowledge.

The magnitude of the problem in Canada is evident when one reads the results of a survey of arthritics carried out by the Dominion Bureau of Statistics in 1947. This revealed that some 652,000 people in Canada were suffering from some form of rheumatic disease. Further, this accounted for 22.6 per cent of total time lost from work as a result of illness during the month the survey covered. The loss to our national income in one year is a substantial sum. To illustrate that arthritis is not merely a disease of the aged, consider the following figures. The onset of arthritis in 74 per cent of cases was under the age of 54. In 34 per cent the onset was under the age of 34. We have known for some time that the number of arthritic sufferers is greater than the

Dr. Robinson practises in Banff, Alta.

number of people suffering from heart disease, cancer, tuberculosis, and diabetes combined.

Before discussing any specific conditions, I would like to give you a simple classification of rheumatic disease to indicate what is included in the field:

1. *Acute rheumatism* (rheumatic fever).
2. *Gout*—acute and chronic.
3. *Non-articular rheumatism*—affects soft tissues and not joints. Includes such familiar conditions as lumbago, bursitis, panniculitis, sciatica, and pleurodynia.
4. *Chronic arthritis:*
   (a) Rheumatoid type (synonym: atrophic)
      i. Unknown etiology—includes classical rheumatoid arthritis and also Still's disease in children.
      ii. Known etiology—includes all forms of infective arthritis, e.g., gonoccocal, dysenteric, etc.
   (b) Osteoarthritic type (synonym: hypertrophic and degenerative)
      i. Unknown etiology—includes senile variety, e.g., malum coxae senilis.
      ii. Known etiology—includes trauma. May be secondary to other joint disease. Central nervous system disease—arthropathy.

It is with osteo and rheumatoid arthritis that I wish to deal in this article. They are by far the most important groups of rheumatic disease from the point of incidence.

Osteoarthritis

This is a chronic joint affection thought to be due primarily to a degeneration of articular cartilage. It affects more men than women. The disease is not a constitutional one but a local condition which affects one or more joints. Though it occurs more frequently in the older age group, it is surprising how often it turns up in a robust male in his forties. It is present, more or less, in the great majority of older people though often symptomless. The main complaints are: pain and stiffness, often worse with changes in weather, in the back, knees, hips, end joints of the fingers, etc.

Osteoarthritis, in the main weight-bearing joints as the hip, for example, often leads to some shortening of the affected limb and the patient may develop a limp as the result of this shortening and local pain. X-ray of the affected joint shows a loss of joint space, normally maintained by cartilage, together with varying degrees of overgrowth of bone about the joint, as though nature were attempting to buttress up this unstable region. Pathologically, the cartilage is worn through over the weight-bearing areas. Over a period of time the opposing bone ends become polished until they are like burnished ivory. In certain joints, as the hip, a contraction of ligaments and joint capsule, together with thickening, takes place which limits movement at the joint. It is in these contracted ligaments and capsule that a great deal of the pain sensation occurs.

The cause of this type of arthritis in the old age group would appear to be simply wearing out of the cartilage. This cartilage, elastic and resilient in young people, becomes less elastic and fibrillated in appearance in older age. With the frequent trauma of weight-bearing, the cartilage gradually wears through. In osteoarthritis in the younger people frequently the cause is more definite. Men working with power drills may develop this in their elbows—a result of frequent micro-trauma. Tailors may develop osteoarthritis at the end joints of the fingers. Injuries, such as fractures involving any joint, may cause the development of a secondary osteoarthritis.

Conservative methods of treatment can give considerable relief to this type of patient. Heat of all forms helps relieve pain. Warm baths, hot water bottles, heat lamps, and diathermy are all of use. In the case of joints with contracted periarticular structures, as in the hip, manipulation under anesthesia often increases the movement and relieves pain by stretching these painful contractures. The use of a traction pull of about

15-20 lb. for several hours daily, in the case of the hip joint, accomplishes the same over a longer time. Work in the deep pool bath enables these patients to do movements and walk in a manner impossible on land. Muscle re-education is also of prime importance in stabilizing the joint and in building up muscles wasted by disuse. X-ray therapy will occasionally relieve severe pain. Local procaine injections into painful periarticular structures also have their place. By such measures as these a good deal can be done to make the lot of the osteoarthritic a good deal more comfortable.

Rheumatoid Arthritis

This is the number one crippler of the chronic arthritis group. It is the disease which, unless checked in its course, may result in complete invalidism. It is a constitutional disease—that is, not just a disease of joints but of the body as a whole. Rheumatoid arthritis is a progressive disease characterized by a polyarthritis, inflammation and wasting of muscles, loss of weight, anemia, fever in the early stages, and an increase in the sedimentation rate. Classically a disease of young women in the childbearing period, today we know it affects all ages and both sexes. Women, however, predominate.

The disease begins insidiously with stiffness and soreness in the fingers in the morning. There is often an associated feeling of lassitude with some diminution of appetite. Swelling usually occurs in the small joints of the fingers, usually at the metacarpophalangeal and proximal inner phalangeal joints. As the disease continues, more joints are involved in a centripetal fashion—the wrists, elbows, shoulders, feet, knees, and hips. Later the joints of the jaws may be involved, resulting in difficulty in opening the mouth and eating. Progression is not usually steady. There are periods of improved health, followed almost invariably by repeated attacks. This insidious progression of damage continues until one day the patient finds himself a cripple. Along the way, the painful joints have caused the muscles to go into spasm and wrists are drawn into a position of flexion, the elbows have become stiff in partial flexion, and the knees may have become bent. The fingers may have assumed a position of ulnar deviation. These joints may become stiff in any position, due to adhesion formation in the inflamed joint. Eventually these fixed joints may become healed by bone formation in these bad positions, to make correction almost impossible. We may be left then with a patient unable to walk, shave, do the hair, or feed himself—malnourished and suffering considerable pain.

Pathologically, the affected joint shows progressive destruction of cartilage from within the joint and from within the bones themselves. Granulation tissue formation destroys and takes the place of the cartilage. There are multiple areas of chronic inflammation in all the muscles of the body with wasting of the muscles. The blood shows a microcytic anemia of varying degrees. The blood sedimentation rate varies from the neighborhood of normal to 100 or 110 points of fall. This is often roughly proportional to the activity of the arthritic process. Studies show a deficiency of most of the vitamins.

The actual cause of the disease itself is unknown. However, we know a good deal about the factors which may cause a recurrence or exacerbation of the disease. Infection of one form or another may start the progression of events which lead to rheumatoid arthritis. The disease continues to progress long after the initial infection is gone, probably as a result of an acquired sensitivity. It may be also that only people with a certain constitution will develop arthritis. The people affected generally are hard workers, who have spared themselves little time for relaxation. Frequently there is an emotional problem of some sort—often these people are worriers.

Treatment of rheumatoid arthritis today has thrown into the discard a multitude of remedies which would fill this page. The student of this condition, should he believe all he

reads, would be a confused man indeed. The great William Osler, at the turn of the century, is quoted as saying, "When I see a case of rheumatoid arthritis come in the office door, I feel like jumping out of the window." Treatments have included: bee stings, cobra venom, injections of colloidal sulphur, non-specific protein therapy, colonic irrigations, vaccines of all kinds, splenectomy, spinal pumping, the use of pregnant women's blood, artificial jaundice, an infinite variety of diets and various forms of physical treatment, including x-ray. Only a few of these are in common use in clinics now.

Therapy offers a great deal of hope today to cases of rheumatoid arthritis. The earlier the treatment is given, the better the chances of recovery. I will mention only the practical approach to treatment and will not comment on treatments in the experimental stages.

If treated early and efficiently, about 25 per cent of cases are restored to normal health and regain full function of joints. Of the remainder, 65 per cent will show functional improvement from mild to good. The residue, about 10 per cent, continue to progress despite adequate treatment. The prognosis is, then, a good deal better than most people realize. Besides this, the great majority of cases can be prevented from developing a major deformity.

Authorities today feel that cases of rheumatoid arthritis should be treated along sanatorium lines. Removal from the home environment and the everyday worries is important. In the years to come, all early cases of this disease may be treated in sanatoria, as tuberculosis is today.

Treatment aims at correction of the constitutional factors, prevention of deformity and correction of existing deformity, together with education of the patient with regard to the nature of her disease and a way of life she should follow. In the early acute stages, the patient is put to rest. Weight-bearing on inflamed joints is eliminated. This prevents further damage to joint cartilages and allows inflammation, pain, and muscle spasm to subside. During the phase of inflammation of joints, which may be present for weeks, all joints are given daily movements by a physiotherapist to prevent adhesion formation. From the beginning muscle re-education, to develop wasted quadriceps, intrinsic muscles of the hand, etc., is instituted. This prevents further wasting and allows muscle rebuilding as the disease subsides.

Inflamed joints are put to rest, whether they be in a position of flexion or not, in light, well-fitting, resting plasters. These may be used for the knees, hands, wrists, elbows, hips, and so on. In such a plaster, pain is relieved a great deal and inflammation settles down. Thus, the spasm of muscles is almost immediately relieved and flexion deformities do not occur. When there is already a flexion deformity, the relief of the spasm allows the knee, for example, to correct gradually to improved positions. The casts are purposely light in weight to allow patients to move their limbs despite the encumbrance. The casts are generally bivalved in about 48 hours to allow daily movements by physiotherapist and muscle education. They are worn until inflammation is gone.

Fixed flexion deformities may be corrected by manipulation after the disease subsides. The constitutional measures are an attempt to correct some deficiencies present. First, however, foci of infection are removed, not because this will cure arthritis but because the presence of a focus lowers general body resistance. Vitamins are added to an already adequate diet. Ferrous salts are given to help correct the anemia almost invariably present. Transfusions may be given to stimulate new blood formation and improve resistance.

There is no specific drug available to us which will cure rheumatoid arthritis. However, the use of gold salt therapy comes as close to a specific drug as any we have. After some years of controversy, it would seem that, until a magic elixir is found, gold is here to stay. It provides our most

effective means of bringing about a remission. It has been stated that with gold one can do in six months as much as would be accomplished in six years without it. The great majority of men working in this field feel that the use of gold has been a great step forward. We do not know how it works—its use is empirical. A course of treatment of 1-3 grams is given in weekly divided doses of 50-100 milligrams. In certain cases, a maintenance dose is continued at three-week intervals for some time. All active cases are started on gold on admission, unless some special condition present precludes its use. It is given under close supervision for it is not a non-toxic drug. With proper care, serious reactions are uncommon.

Hot baths or deep pool bath therapy can be given as the activity of the disease subsides. These are used for several reasons. First, in hot springs we have the cheapest form of heat available and this is a great help in relieving pain. Secondly, this therapy is of help in teaching those people who have not walked for months or years to walk again. The extra buoyancy of mineral waters is of some help in this regard, as it allows easier movement. Gradually, these people are graduated to walk again on land.

Under this regime, the patient with early rheumatoid arthritis should count on at least three months' supervised treatment. Later cases require longer periods of time. During the period of hospitalization, lectures are given to educate patients as to the nature of their disease and after-care. Simple methods of applying home remedies, such as heat, are demonstrated. The patients are warned of those factors that may cause recurrence. Over-fatigue, infections of the nose and throat, insufficient rest, and exposure to cold and damp are all factors to be avoided. After the acute phase has subsided, patients are allowed increased liberties.

The nursing staff plays a large part in determining the comfort and morale of these long-term patients. The nurse must know with what she is dealing and remain cheerful and helpful in the face of a physically ill and often emotionally disturbed patient. Cheerful and bright surroundings make a great deal of difference in eventual recovery. In Banff, for those patients that are up and about, there are frequent movies shown in the hospital and occasional bingo games. Most community entertainment makes a one-night stand at the hospital. All of these things make a break in the long stay. Other countries are well ahead of us in Canada in treatment and care of arthritics. Sweden has 3,000 beds set aside for treatment along these lines. England has a country-wide scheme for case-finding and treatment.

In Canada, there is a nation-wide movement to start a program of treatment and research. The Canadian Arthritis and Rheumatism Society has been formed with the help of the Canadian Rheumatism Association. This society is set up with both lay and medical directors to organize training and education, and support research and treatment centres for our 650,000 arthritics. Alberta is at present leading the way in Canada by studying legislation to provide free hospitalization and treatment for arthritis victims under the age of 20.

We hear arguments today that more should be known of the cause of rheumatoid arthritis before money is spent on treatment centres. It is true that a great deal of research is needed. However, we should not deny those suffering from the disease today the relief that can be given by adequate medical and orthopedic management. The treatment of tuberculosis has changed little in the years since the discovery of the causative agent because these patients are being treated by sound medical and physiological methods. Treatment now can save thousands from crippledom.

Your heart weighs less than a pound, yet it pumps hard enough to lift a ton seven storeys high every 24 hours.

Problems in Nursing Arthritics

E. JERMYN

Average reading time — 4 min. 48 sec.

MOST NURSES who have had the care of arthritic cases find that the endless patience required of them is the most difficult aspect of this branch of nursing. At one time I thought of nursing in an arthritic hospital as a tedious round of lifting heavy people, feeding helpless ones, and generally dealing with irritable chronic patients. Now, after experience both as nurse and patient in a hospital with a daily average of 60 arthritic cases, I know the picture is not nearly as grim as that. Instead, the cheerful attitude of both patients and staff helps to make the atmosphere the happiest that I have ever known in a hospital. The majority of patients are able to be up and about and require the lightest of nursing care, so that one has sufficient time, without being rushed, to devote to those who need a great deal of care.

Arthritic cases vary from those who have come early for treatment, and may have only one or two joints involved, to those who have received no treatment until they are helpless cripples with deformed and ankylosed joints. In age they may run from 5 to 75, but the majority are in the young adult group and more women than men are affected. This refers particularly to rheumatoid arthritis, the type that produces the greatest crippling and deformity and is also the most painful.

The treatment of rheumatoid arthritis which has produced the best results so far consists of injections of gold salts, rest, extra vitamins and iron where indicated, relief of pain by aspirin compounds, and physical therapy.

Gold injections are usually given weekly and toleration of gold must be checked by weekly urinalysis and bi-weekly white blood count. Progress is shown by checking the sedimentation rate and hemoglobin every three weeks.

Physical therapy consists of daily manipulation by a trained masseur to loosen stiffened joints and to prevent new deformities. Daily mineral baths, in pool or tub, provide an opportunity for heat treatment and underwater exercises. The buoyancy of mineral water is an aid to exercising and gives support to those who are learning to walk again. Supervised group exercises, paraffin baths, etc., are given where indicated. Occupational therapy plays an important role in treatment, not only from the point of view of promoting muscle and joint movement, but also as a stimulus to interest in a hobby or trade and to maintaining good morale. This is supplemented by recreational therapy in the form of weekly motion pictures, bingo parties, sing-songs, selected games, and so on.

Resting casts are made for swollen or deformed joints, usually knees, hands, or elbows, and these are applied with crepe bandages for as long as possible each day. They are made with the joint in the most normal position possible. As a greater degree of flexion of the joint is obtained, the casts are remade. In some cases casts cause a great deal of discomfort at first. In time they become more bearable and later afford comfort to painful joints.

Diet should be generally well-balanced, high calorie, average protein, high vitamin content. These patients are usually admitted in a more or less run-down condition. The only restrictions are spices, condiments, concentrated sweets, fried foods, and pastry. Patients who are obese are put on a reducing diet.

Nursing bed-ridden arthritics calls for an exceptional amount of patience

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Miss Jermyn won first prize given by the Arthritis Club of Banff, Alta., for the best essay on "Nursing in Arthritis." She is on the staff of the Mineral Springs Hospital, Banff.

and gentleness in handling. Because of the extremely painful condition of the patient's joints any quick or jerky movement is distressing, so morning and evening care is a slow and tedious job. A knee a fraction of an inch to one side or the other, or a pillow not quite right, makes all the difference between comfort and misery. Moving a limb too suddenly or a sudden jar is enough to cause needless additional agony.

Bed-clothes should be warm but light in weight. It is hard to realize, without experience, the misery and exasperation of trying to adjust blankets around one's neck with hands that are unable to grasp anything heavier than a handkerchief. Light bedding also facilitates changing position at night. Trying to turn even a few degrees is a slow and difficult procedure, especially for those whose joints and muscles are acutely inflamed. This produces a tendency to lie very still all night long with resultant stiffness in the morning.

As with all chronic bed-patients, special care must be given to the back and all pressure points. Be careful not to leave the patient on a bed-pan too long, as there is pain associated with this position.

With those who are able to be up and about the nursing care is much simpler and little actual attention is needed apart from making beds and giving medications. Women may need help in "doing their hair" or getting in and out of the bath-tub and some will require aid in tying shoe-laces or getting arms into dressing gowns. The nurse should see that casts are applied comfortably at required times; also that her patients take sufficient rest and do not overtire themselves when they begin to feel better. Rest is an important part of the treatment.

From a patient's standpoint, gentleness, understanding, and cheerfulness on the part of the nurse are the most important attributes. Arthritic patients are, as a rule, of a remarkably cheerful and happy disposition no matter how hopeless their condition seems. There are bound to be times of depression when understanding on the part of the nurse is of invaluable assistance to the patient's morale.

Any effective treatment of arthritis, even in the early stages, requires several months of hospitalization. Many of the patients have to return several times for additional treatment. Thus the nurse is working with the same people over a long period of time and comes to know them well as individuals. They are victims of an insidious and relentless disease which afflicts 5 per cent of our population and which, up to the present, has been virtually neglected by medical science. Today, for the first time, research work is being stimulated and there is hope of cure or at least improvement for many of its victims. By giving her best the nurse can feel she is doing her part in this battle which is well worth fighting.

Some Allergies Said Prenatal

Many infants are sensitive to certain foods they have never eaten because they had been so sensitized before birth, states Dr. H. E. Edwards in an article—"Food Allergy"—in the Memo to Mothers section of the Health League of Canada's magazine, *Health*. Dr. Edwards is with the Hospital for Sick Children, Toronto, and the Department of Pediatrics, University of Toronto.

"This may occur when a pregnant mother gets a food craving and over-indulges," writes Dr. Edwards. "Some of this food gets into her bloodstream and through to the baby's bloodstream and may sensitize receptive cells.

"An example of this is the finding of a baby who is sensitive to chocolate and its mother who admits the over-indulgence of chocolate during the latter months of pregnancy, either to satisfy a craving or to disguise the taste of the milk she drinks."

A change brought about by the British National Health Service is that whereas formerly pharmacists filled only some 40 per cent of all prescriptions of the medical profession, they now fill 100 per cent.

Occupational Therapy for the Chronically Ill

MARGUERITE E. STOCKER

Average reading time — 22 min. 24 sec.

BY THE TERM "chronically ill" we mean any patient, young or old, who is suffering from a prolonged illness and who will benefit from hospital care. The rise in life expectancy from 40 to 65 years, the shift of the population from rural to urban areas, housing shortages, and increased costs of living have resulted in families being unable to support any member of the family who may have become financially dependent due to illness. Thus, the hospital population is greater. These people are the community's care—local, provincial, and federal governments must all assist. We must work together as a team—doctors, nurses, physical and occupational therapists, social workers, and other allied workers—to substitute for the home and to arouse in these patients such health, happiness, and comfort that they will have a real interest in life and a zest for living. Of course, this must fall in with their active and routine medical care.

Occupational therapy may be defined as any activity, mental or physical, medically prescribed and guided, contributing to or hastening the recovery from mental or physical illness. Occupational therapy must be controlled by the doctors and watched by the nurses to ensure its contribution to the well-being of the patient. Manual occupation with mental satisfaction results in forgetfulness of physical discomfort and handicaps, zest for accomplishment, a feeling of worth, and, often, development of manual dexterity. It induces better sleeping and eating habits and a healthy outlook on life.

What can be done where there is no occupational therapist? When the nurses realize the need for something more than routine care for a positive treatment, they might turn to the hospital auxiliary for help. If one has not already been organized, this could be a valid reason for its formation. The shopping, preparation, distribution, and teaching could be done by members of the auxiliary. It would be the nurse's responsibility to inform the workers of the patients' handicaps, precautions to be taken, best working positions, and any mental hazards to be guarded against. Also, it would be advisable for the nurse to suggest the patients' projects. She has an opportunity to observe a patient's likes, dislikes, and his capabilities much more than someone who visits him once or twice weekly. It would be her responsibility to check working time and to provide space for the storing of unfinished work. Also, if she were there when the work was being described to the patient, she could assist the patient when he or she is having difficulty.

Before I suggest actual projects, I shall mention two other factors. First of all, the *value of color* should be considered. There are so many beautiful hues of wools, felts, etc., and patients do love them!—Why not use them? They cost the same as the drab ones. Also, it is most uplifting for the patients to *go to another room to work*. If no regular O.T. workroom is provided, a pleasantly furnished sitting-room could be used. The atmosphere is much more homelike and relaxing than that of a ward. It means more to a patient than words can convey.

Volunteers go to the Junior Red Cross Children's Hospital in Calgary each Friday afternoon for two hours to teach a group of patients his or

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Miss Stocker presented this paper at an annual meeting of the Alberta Association of Registered Nurses.

her particular hobby. One group is taught basketry by a volunteer from the Canadian Institute for the Blind, another ceramics, another leather-craft by a scout-master. Other groups are taught a variety of crafts by members of the Calgary Allied Arts Centre. This "Hobby Afternoon" is a big time for the children. It is easily controlled, being a regular affair and a special treat after studies all week.

A project which might easily be overlooked is education. Students, whose education has been interrupted by illness, can continue their work through the excellent help of the Correspondence School Branch of the Department of Education. Students are given full credit for work completed in their grades while attending school. We have found at Central Alberta Sanatorium that children of grades as low as "two" worry about returning to school and finding themselves behind their former classmates. The courses are well outlined and excellent supplementary reading is provided. Perhaps a former teacher in the community would volunteer to assist and encourage these children.

There are numerous correspondence schools which offer excellent courses for adults who desire to acquire learning in a new field, enrich their knowledge of their present occupation, or merely enjoy some new interest. Among the courses available are: shorthand, typing, book-keeping, accounting, salesmanship, motor mechanics, commercial art, draughting, business English, etc. For those whose position is restricted, there are excellent adjustable bed-tables. They allow the patient to type while he is lying flat on his back. The board or table is a draughting-board so it is possible for a patient to do any type of draughting, drawing, painting, as well as providing an excellent book-rest.

Simple crafts, using material that is easily obtainable and requiring little preparation, may appeal to the patients. Foremost among these is weaving. It is an ancient art. It can be simple or complicated. Patients are advised to attempt the simple type first. Children and adults with restricted movements love "Weave-its." Ordinary knitting wool can be used on these small frames to make squares. Scarves, bags, and afghans can be made by joining the squares together. The box or cradle-type of table loom is a little more involved. Knitting wool, warp (cotton or carpet), or "Weavecraft" weaving wool may be used. Men really enjoy weaving and our patients delight in making their family tartans in scarves and materials.

Another ancient craft is needle-point in its two forms—*gros point*, meaning a large stitch, and *petit point*, meaning a small stitch. All supplies are easily obtainable now. The work is light, fascinating, and colorful. It does require good eyesight and good lighting. Where the patients are restricted in time and effort, this is an excellent craft. We started it a year ago at the Sanatorium and no girl has been able to resist its fascination and leave without doing at least one piece.

Rug-making is a craft enjoyed by both men and women. There are two types among the many that are most practical and interesting to make. First, the donegal or turkey rug that is an all-wool yarn rug. It is expensive—materials for one rug, 2'3" x 4', cost about $13. However, the rug will last a lifetime and can be vacuumed. This type of rug is colorful and can be made in any design or shape. No frame is required so it can be made by the patients confined to bed.

Another type of rug is the braid-woven mat. A three-strand braid of dyed silk stockings or folded cotton strips is sewn together on the reverse side. These can be most attractive. Their beauty depends upon the choice of colors used in dyeing stockings or in choosing material. A very pretty result can be obtained by dyeing a large number of stockings at once. Nylons and rayons dye different shades, which blend beautifully when braided together. Nurses' cast-off stockings are excellent for dyeing.

No equipment is necessary for this type of rug-making. They are most suitable for women to make.

Shearling toys are attractive and easy to sew together. Six toys can usually be cut from one skin. The overall cost is about $1.30 per toy. No equipment is necessary except a needle, linen thread, and a razor blade to cut the shearling. Any small toy patterns with few pieces are suitable. We make lambs, scotties, cocker spaniels, rabbits, and bears.

Children should be given educational toys as often as possible so that they may grow mentally alert. Strings of spools or colored beads strung across cots amuse small youngsters. Cutting with blunt scissors, pasting, crayoning, folding paper, dressing dolls, etc., provide endless enjoyment. Books can be made from the crinoline off elastoplast bandages. Christmas or birthday cards make the best pictures for these small books. They are gummed to the crinoline then the pages can be sewn down the back on the sewing-machine and the edges can be pinked. These books will not tear and can be discarded when soiled without any loss. Musical records, books, studies, nursery rhymes, games, soap carving, knitting, clay work, leathercraft, and beadcraft are among the many possible suggestions for maintaining and improving mental activity and providing an outlet for pent-up physical energy among children.

Clay work, "ceramics," has increased greatly in popularity recently. Where there is no kiln or opportunity for firing clay models, "modellight" clay, a self-hardening type, is an excellent substitute. This medium of expression is excellent for arthritics. The clay is soft, not injurious to the joints, and yet it encourages mobility. It is an inexpensive craft. There is no end to the variety of objects that can be made—brooches, ear-rings, ornaments, candlesticks, vases, pictures, jugs, cups, lamps, plates, etc.

Plaster of paris makes lovely plaques. It is mixed with water, poured into a mould, and allowed to dry and harden. Babies' rattles, split in half along the seams, make excellent forms for plaques. The plaques will fall out of the forms when they are sufficiently dry. They can be painted with water colors and shellacked with colorless nail polish. Hairpins or paper clips may be inserted while the plaster of paris is still wet, thus making hangers for the plaques, or gummed hangers may be applied when the plaques are completed. It is an extremely simple activity but there is no limit to the imagination that can be used in the painting.

Felt, also, provides many colorful and diversified activities. It is easy to handle and is a material which does not irritate arthritics. Hand-bags, knitting bags, slippers, flower ear-rings, Mexican appliqué boleros and jackets, caps, card table covers, belts, and pictures are among the articles suggested. Very attractive pull toys can be made by attaching wheels or spools to the base of felt toys.

The patients at Central Alberta Sanatorium have found uses for discarded x-ray films. They wash them clear, cut them into shapes according to pattern, put a pretty flower from a card on background paper between two layers of film. These are punched at the edges with a paper punch and crocheted together to form baskets. Doll house furniture, rectangular jewel boxes, sewing baskets, and bookmarks are among the other articles that can be made in a similar manner from old film. The only expense is the crochet cotton.

Work on frames is easy and attractive to both men and women. The men make place-mats and cushion tops using cotton warp. The women also make place-mats but usually prefer dressing-table mats of faultless cotton. The shuttles for tying can be made from plastic strips or from flattened spikes. Punchwork cushion tops and bags require an 18″ wooden frame, thumb tacks, an 18″ square of velveteen, a pattern on cotton, and a hook. The patterns indicate the shades to be used so there is nothing difficult, yet they are colorful and

attractive. All supplies are available at needlework departments in the larger stores. This craft is popular among men.

Leathercraft is a much more difficult craft. The supplies and equipment are expensive. If there is someone on the staff or a volunteer qualified to teach it, all well and good, but do not start without sufficient knowledge. It is a wonderful craft in that it takes a lifetime to learn all that there is to know and it can be graded from very simple work to most ornate and difficult designs. Link belts, braided belts, and dog leashes are excellent projects for boys as these can be made with no equipment.

Wood-carving, to make ornaments, pictures, trays, requires only one tool—a jack-knife. If necessary, a gouge may be improvised. Pine and basswood are good materials for the beginner. A cake of soap makes an excellent practice block.

The list of possible crafts is almost limitless—silverwork, plastics, woodworking, shell work, photography, stamp collecting, story and poetry writing, embroidery, knitting, crocheting, smocking, dressmaking, fly-tying. Recreation is important, too—active and quiet games, musical recordings, and the radio all assist to make life more enjoyable. Never forget the seasonal parties! So often a patient leaves the Sanatorium saying, "I didn't have time to do so many things that I wanted to do!"

This combination of work and play will provide a hobby for patients who are going home to convalesce. Perhaps then they can do some of the things they have seen being done and wanted to do themselves. For some their hobby becomes their vocation when they are discharged.

There are so many extremely interesting activities that the nurse who is willing to sacrifice a few minutes of her time to encourage the patients will be rewarded immeasurably. Nursing care will be easier and a happier atmosphere will prevail. We look forward to the day when there will be Occupational Therapy Departments in all hospitals. Until then, may we all remember that the patient is a whole personality. We must treat not only the physical ills but satisfy his mental needs. We must prevent mental stagnation and keep the body working to the best of its physical capacity as long as possible.

Definitions of Functions

SISTER MARIE-JEANNE TOUGAS, S.G.M., B.Sc.

Average reading time — 8 min 48 sec

THE Nursing Service Organization of the Regina Grey Nuns' Hospital has studied, at its regular meetings, the following principles of sound organization and administration:

1. There should be centralization of executive authority.
2. The lines of authority should be well defined.
3. There should be delegation of authority commensurate with the responsibility given.
4. There should be definite assignments of duties and provision for checking of duties.
5. There should exist a spirit of cooperation.

As a result of this study, an attempt was made: (1) To define the various titles as used in the institution; (2) to indicate the lines of authority and (3) the relations and the duties of the different persons employed in nursing service, namely: the director of nursing service, the supervisors, the head nurses, and the clinical nurses on general duty.

Sister Tougas is chairman of the staff program at the Regina Grey Nuns' Hospital.

Director of Nursing Service

This is the person responsible for the organization and administration of the nursing service in the hospital.

Authority: She is responsible to the administrator. She should work closely with the director of the school of nursing and the chairman of the staff program. She has authority over supervisors, head nurses, and all department heads as far as nursing service is concerned.

Functions:

1. To make sure that the hospital provides a good quality of service.
2. To work in cooperation with all the other members employed in nursing service.
3. To maintain good relations with the medical staff on matters concerning nursing service.
4. To report to the administrator.
5. To investigate into needs of departments.
6. To report shortage of personnel and advise as to employment.
7. To see that proper working and living conditions and proper health service are available.
8. To keep records of functions of various personnel; of qualifications necessary in relation to position; of criteria used in promotion.

Supervisor

A clinical supervisor is a graduate and registered nurse who is responsible for intelligent nursing care of patients, the educational development of student nurses, the work of other members of the personnel within her department, and the care of equipment and supplies.

Relationships: There should be a democratic working relationship between the supervisor, the director of nursing service, the director of the school of nursing, the clinical teachers, and the head nurses within her department. They are co-workers with the same fundamental objectives in view but, because of the broader experience and qualifications of the supervisor, she holds the senior position which is one of authority.

The supervisor should provide the type of leadership that will allow the head nurses to fulfil their rightful responsibility in regard to the patients, the students, and the hospital, and encourage them to feel the significance and importance of their position.

The supervisor has a number of responsibilities toward: the administrator of the hospital, the patients, the members of the medical profession, the graduate nurses and the students, the community at large through patients' relatives and friends.

Qualifications:

1. The supervisor should possess sufficient "job intelligence" to perform her duties efficiently—i.e., she must possess all the necessary functioning information for the management of her clinical department.
2. She must merit the respect of those whom she is supervising; she will do this best by respecting them and never asking them to do a thing which she herself would not accept to do.
3. She must be an organizer and have executive ability.
4. She must be a helpful counsellor and a stimulating leader of her head nurses by virtue of her experience, preparation, and qualifications.
5. She must be just in her dealings with those supervised and her criticisms must be constructive.
6. She should see that facilities for carrying on the work are adequate and try to manage the whole situation at the lowest cost possible to the patient and to the hospital.
7. She should help to organize the activities of the personnel under her and develop a system that provides for the smooth, efficient running of her department day and night.

Duties: These may be classified under the following four main headings: Nursing, Management, Teaching, Housekeeping. The supervisor must:

1. Make a job analysis of the entire ward situation in order to improve all the phases from nursing to housekeeping, so that the hospital may achieve its aim.
2. Play the part of a hostess.
3. Staff the ward with the nurses sent to her and provide the proper nursing experience to student nurses.

4. Plan the work with the greatest possible degree of efficiency; make assignments; check on the performance of duties assigned and the progress made by the individual.

5. Adequately supervise the nursing care being given so that the quality will be maintained or improved.

6. Cooperate with any plan for the upbuilding of the hospital, the education of nurses, and be interested in the development of good methods of nursing care.

7. Have a broad professional outlook—i.e., be a student in the nursing educational field.

8. Audit the lectures which are related or which pertain to the nursing in her particular department, whenever possible.

9. Find time for personal conferences with head nurses, students, or employees.

10. Appreciate the efforts of her subordinates and acknowledge their progress by recording achievements on efficiency reports.

11. "Keep house," that is see to repairs, replacements, equipment, supplies, linen, meals, cleanliness in rooms, etc.

Head Nurse

She is one who shares the duties and responsibilities of the supervisor. She holds a key position in that she is the closest to the students in their practice field and is also in direct contact with the patients and medical staff. In conjunction with the supervisor, the head nurse is directly responsible for the nursing care of patients.

Relationships: There should be an understanding and cooperative relationship between the head nurse and the supervisor. The head nurse should recognize in the supervisor a person of wider experience to whom she should look for help and guidance. She must keep her supervisor informed about all the important activities and events of the department in her absence and she should cooperate in every way she can with departmental policies, regulations, studies, experiments, and other plans initiated for the improvement of the service.

Professional attitude: Because of the nature of her position, personality qualities will have a direct influence upon the students and the patients. Her influence will tend to foster or destroy the spirit and attitude of the students in regard to nursing. From the point of view of the patient it is important that she be tolerant, sympathetic, and tactful, thus promoting a sense of confidence and security.

Professional preparation: Before assuming the position and responsibilities of a head nurse one should have preliminary experience and preparation. This preparation should comprise: (1) At least six months on staff as general duty nurse; (2) an additional six months as assistant head nurse. This preliminary preparation would be helpful in giving her a general understanding of ward administration. The essential qualifications that every institution expects to find in a head nurse are: an able manager, capable housekeeper, a skilful bedside nurse, an effective teacher, a good cooperator, as well as a person with high professional standards.

Duties: The head nurse should see that the patients are receiving the best possible nursing care. In order to do so she must know what skilful professional nursing care is, how to give it, and how to provide it for the patients. She should know all the patients individually, their needs as well as their physical condition, their treatment, medications, and the progress they are making.

The medical staff should be able to depend on her expert knowledge and skill with respect to the administration of such care. She, in turn, should be able to secure expert counsel from her supervisor as she needs it.

The assistant head nurse shares all or part of the duties and responsibilities of the head nurse.

The Staff Nurse

Clinical nurse on general duty is the person who performs the nursing service of a general nature in any department of the hospital.

Qualifications: The general staff nurse should be expert in administering nursing care to her patients. Her presence, attitude, and manner

of work have a definite influence upon the students with whom she comes in contact on the wards. From this point of view it is important to select graduates who have a wholesome attitude towards their work and the school.

REFERENCES

1. Aniceta, Sister M. Supervision in Schools of Nursing. St. Louis University School of Nursing, Summer Session, 1934.

2. Clermont, Sister D. Titles and Definitions. *The Canadian Nurse*, May, 1948.

3. Canadian Nurses' Association. *A Proposed Curriculum for Schools of Nursing in Canada*. Editions April, 1936, and April, 1940.

4. National League of Nursing Education and Canadian Hospital Council. *Manual of the Essentials of Good Hospital Nursing Service*. Editions 1936 and 1945.

5. Wayland, McManus, Faddis. The Hospital Head Nurse. The Macmillan Company of Canada Ltd., 1945.

The Nurse and the Law

CARL LEDOUX

(*Continued from June, 1950, issue*)

I RECALL one case in North Vancouver some time ago, where a pedestrian was knocked down by a motorist who had been drinking. The motorist fled but was apprehended by our men. He denied the allegations made by the police and stoutly asserted that he had not struck anyone, despite the fact that his headlights and windshield were broken. In order to supplement other evidence, the victim's coat was sent to our laboratory where it was minutely examined for paint or glass fragments. No paint was found but there were some tiny particles of glass. Pieces of the windshield and headlights of the suspect car were sent over for spectrographic analysis. This proved negative. Neither windshield nor headlight glass corresponded to the fragments found on the coat. A radio message was sent to North Vancouver, inquiring if there had been any other glass on the car in question. Immediately a reply was received that the only other glass was in the motor-meter, a type of thermometer mounted on the radiator of old model cars. It was sent over and tests showed this glass to be identical with that found on the victim's coat. A conviction resulted.

I recall a case I had in Chilliwack a number of years ago. A man and his wife were struck down while walking on a dark highway west of that city. The victims were taken to the hospital at Chilliwack by a passing motorist and I was advised. At the hospital I gained possession of the victims' clothing for inspection. A quick check was made and from information received the suspects were narrowed down to a small number. Inquiry at the home of one of these showed that he was in bed and apparently had been home for hours. Not quite satisfied I went to the garage and found the radiator of his car still quite hot. The exhaust pipe was still warm, indicating the vehicle had been recently used. Further examination showed that the car had been recently painted with cheap enamel. While quite dry the paint had not "set" properly and could be indented with the finger-nail. I examined the front of the two fenders closely and located an area where the soft paint had been "engraved" with the pattern of a piece of cloth. There were several fibres embedded in the paint and these corresponded to the coat removed from the male victim.

The pattern of warp and weft, or the weave of the cloth, matched the engraving. In view of the evidence against him, the culprit admitted his offence and pleaded "guilty" when charged.

Another case I recall was when a Chinese was brought to one of our Vancouver Island hospitals, suffering from injuries received in a mining accident. His clothes were filthy, ragged, and torn by a blast of dynamite. When removed, they were taken out to the back but, fortunately, not burned. Instead, they were hung on a line. Some time later, some of the patient's friends, after visiting him, asked the nurses where his money was. They were very much surprised to find that the Chinese had been carrying $600 on his person when working, as he had no other place to keep his money and did not believe in banks. They at once went to the clothes-line and retrieved the disintegrating pair of trousers in which they found the entire $600 quite intact.

In cases of homicide or assaults of a murderous character, clothing plays a very important role. For instance, bullet holes may tell a story. There are means of estimating the distance from which a fire-arm was fired by the powder pattern on clothing or flesh or, in the case of a shot-gun blast, by the area covered by the pellets. This may be very important in showing whether the shooting was in self-defence or with murderous intent.

There is one case in which I assisted a couple of years ago which illustrates this point. A man was charged with attempted murder after shooting his stepson. The culprit claimed that the boy had shot himself while they were struggling over the possession of a gun with which the boy had threatened his stepfather. The boy's story was quite different. He stated that his stepfather had lain in wait for him and shot from a distance of perhaps ten or twelve feet without warning. The boy had then closed with his assailant and, wounded as he was, wrested the gun away from his stepfather, knocked him out, and phoned for the police before fainting away.

Here was a case of one man's word against another's, and the prosecution was faced with the legal maxim that the accused must be given the benefit of any reasonable doubt. It was quite evident that some expert evidence would be required to determine the actual distance from which the shot had been fired. The pattern of shot-gun pellets on the boy's back covered a certain well defined area. As you all know, a charge of buckshot fired from a shot-gun assumes a cone shape, widening as it travels farther and farther from the muzzle of the weapon. Working on this principle, our ballastics expert made a series of tests with the fire-arm in question. Identical shells were used and a series of test shots were made at distances from one-half inch up to fifteen feet from the muzzle. From these test shots, a chart was prepared showing the cone of fire. Consultation of this chart showed that the minimum distance between the gun muzzle and the boy's back must have been at least eight feet and probably much more. This entirely negated the culprit's assertion of self-defence. The ballistic evidence, coupled with the other facts of the case, resulted in a conviction and a sentence of twenty years at hard labor. The culprit had a criminal record and had been married a number of times, most of his wives disappearing inexplicably.

While there are many cases of this kind which could be told, the foregoing will serve to illustrate my point. Suffice it to say that clothing is frequently of paramount importance to the proper presentation of a criminal case. Every care should be taken in the preservation of garments. If wet, they should be dried by normal means, excessive heat being avoided as this may destroy evidentiary material. Clothing should not be allowed to remain wet. Wet blood tends to putrefy but keeps indefinitely when dry. There may be some stains on a garment which are not the victim's blood. Those stains are possibly due to some injury sustained by the attacker and, therefore, if sufficiently

preserved to make a blood group determination would be of great value as evidence.

When a patient is being undressed preparatory to surgical or other treatment and it is impossible to remove the clothing by normal means, it is suggested that *the seams of the clothing be ripped*, instead of cutting the clothes off indiscriminately with a pair of scissors. The latter course may destroy invaluable evidence which can never be restored.

Some notation should be made of the time, date, and place when garments come into your possession. They should be handled by as few people as possible so that the "chain of evidence" will not involve many witnesses to prove the continuity of possession.

Notation should be made of the condition of the garments when they come into your possession, such as whether wet, or soaked with blood, covered with dust, caked with mud, and so on. Searching clothes should be left to a competent investigator who will be better equipped to locate possible evidence and preserve it for future use. When the garment is dry, it should be placed in a paper bag provided for this purpose. In this way, any small amount of hair or fibres or perhaps minute particles of vegetation, soil, or gravel, adhering to the clothing, will be preserved for examination.

Another very important point I would like to draw to your attention is the recovery of fatal bullets. Occasionally a person is shot with a low velocity projectile or one that has travelled a considerable distance. The bullet may have sufficient energy to penetrate the clothes and skin of the victim, then travel right through his body to emerge from the other side. However, the last bit of energy may have been expended in passing through the final layer of skin. And so, instead of going right through the victim's garments, it will drop between skin and underclothes. When the patient is disrobed, the bullet will probably roll unnoticed to the floor and be swept away. So another valuable piece of evidence is lost completely.

Where there is an exit wound on the patient, and no corresponding hole in the garments, great care should be taken to avoid losing the valuable projectile. In one case that I recall, a bullet was lost in this manner. They hunted high and low but were unable to locate it. Finally, giving up, the clothes were put away. One of the officers noticed something rattling in a shoe, reached in, and there found the missing bullet. It had wormed its way down through the victim's underwear and into his sock, thence through a hole into the shoe.

Perhaps a word or two regarding bullets and their use as evidence in cases of gunshot wounds would be valuable. Every fire-arm of the rifled variety has a definite pattern or engraving inside the barrel which is peculiar to that particular weapon and no other. This is caused by the tool marks left in the barrel when the weapon is rifled. The minute scratches are impossible to duplicate and the pattern changes as the tool wears away with every cutting. When a soft lead bullet or even a hard-cased bullet is fired through the barrel, it acquires the pattern of scratches of that particular weapon. An expert in fire-arms examination may then determine whether or not a fatal bullet was fired from a given weapon. As the engravings are microscopic, it is very necessary that the bullet be kept free from all damage and that it should under no circumstance be removed from a body with forceps or other metallic means if this is avoidable. The instrument will flatten the delicate pattern and render the bullet useless as a major piece of evidence.

Great care, then, should be taken in handling bullets found in or about the body of a shooting victim. They should be preserved in a small vial or pill-box with a little cotton wool. Again there should be a record of the time, date, and place where the bullet was recovered and, of course, if the physician or autopsist removes the bullet from the body he will also have complete notes on its original position in the victim and the course it took.

The care of metal fragments does not only apply to bullets but many other pieces of metal may be of prime importance. For instance, in United States records there is a case of where the victim of a hit-and-run accident was brought into hospital for treatment. He died and in the autopsy that followed it was found that an automobile curtain stud, such as was used on old-fashioned touring cars, was embedded in his head. This stud, which has a similar appearance to a 22-calibre bullet, though smaller, had entered the skull sideways and left a perfect pattern of its profile. Later the stud was valuable in proving the identity of the hit-and-run car.

It is very difficult to advise you what to look for in any such accident or injury. All cases differ and I can only give you a brief outline of points which may arouse your interest and prompt you to observation when the circumstances warrant. Many of the points which I have mentioned and which I will discuss are perhaps in the autopsist's field, but there is no harm in your also learning what may be of use in evidence.

Foreign material in a wound can be of major importance, proving that a certain contaminated instrument was used or perhaps indicating where the assault took place. The contents of the stomach, though devoid of poison, may give a great deal of valuable evidence. That reminds me of a case in Boston some time ago. A young woman was found dead on a park bench. She had been strangled but there was absolutely no evidence either of her assailant or of her identity. The medical examiner ascertained from the temperature of her body, and other post-mortem indicia, that she had not been dead over an hour when discovered. As the body had been found around 7:30 p.m., the medical examiner reasoned that the victim should have some indication in her stomach contents of what and when she had last eaten, which might be of value in tracing her movements. A post-mortem was done at once.

The contents of the stomach revealed much more than the medical examiner had expected. There was evidence that the victim had consumed a meal within a half-hour or so of the time she met her death. The meal had been one cooked in the Italian style and had contained such material and condiments as ravioli, green peppers, celery, ripe olives, and raisins. With this information a canvass was made of all the restaurants in Boston which served meals of this kind. The investigating officers interviewed the waitresses and asked them whether they had served a young woman of the victim's description with such a meal within the last couple of hours. Finally one girl was found who thought she had served the victim. On being brought to the morgue, this was confirmed by her definite identification of the victim. However, she did not know the girl, in fact she had never seen her before that night. The victim had dined in the restaurant with a man but the waitress did not know him either. On being further questioned, the girl recalled that the man had eaten in the cafe on a previous occasion with another man whom she did know. The police were not long in following up this clue with the result that the assailant was in custody within twelve hours of the murder.

To return to our discussion, anything which the victim of an assault or other form of crime involving the person has with him, or about him, should be safeguarded. A cigarette case or a pocket flask, or perhaps a mirror, may have the assailant's finger-prints on it. *Don't*, as they do in the movies, *carefully wrap the article in a handkerchief and put it away*. This is the surest way of obliterating the entire latent fingerprint, or at least in blurring it to the point where it will be valueless as a means of identification. The article should be placed in a receptacle where the suspected surfaces will not come into contact with anything at all.

When preparing a person for medical care, attention should be given to his or her hands. They may be cut or scratched when the victim attemp-

ted to defend himself, and thus indicate the type of weapon used in the assault. Again in fighting off the attack, the victim may have scratched or gouged the attacker's face or hands. There may be tiny fragments of epidermis under the finger-nails or even flecks of blood.

Where we find dead bodies showing marks of criminal assault, one of the first things we do is to remove the finger-nail scrapings and preserve them for later examination. Quite often there may be a hair or two which will be of assistance in identifying the culprit. A great deal may be learned from a single hair. An estimate can be made of the race, whether male or female, whether it comes from the head or elsewhere and, perhaps, how recently it has been cut. If the hair is pulled out by the root, additional information may be secured. You will see, therefore, that a single hair may be a big help in the solution of a crime.

A rather unusual, but nevertheless interesting, factor in the examination of victims of homicidal violence is the presence of teeth marks. If such marks are found, they should be drawn to the investigator's attention. They can be photographed and thus preserved. If they are of a peculiar character or pattern, they may later be identified with the assailant's denture, thus adding another piece of evidence to the case.

In at least one occurrence I know of, lipstick marks told a story of murder. This case happened in the eastern United States some time ago. A young woman was occupying a room in a hotel. The chambermaid came around in the morning to tidy up the room but found the occupant apparently fast asleep. The maid retired quietly. Some time later, the maid returned to the room, knocked and, receiving no reply, opened th door. She found the sleeper in identically the same position, so she stepped up to the bed and took a closer look. The woman was dead!

Hurrying to the hotel office, the maid babbled out a story of finding a dead woman in room so-and-so. The hotel clerk at once sent for the police who in turn notified the medical examiner. A routine investigation was made. It appeared that the young woman had died of natural causes and the medical examiner was just about to leave when he detected small hemorrhages in the whites of the eyes close to the nose. They were very slight and a few hours of post-mortem change would no doubt have obliterated them entirely. These, however, made him suspicious and he carefully examined the bed. He found it quite orderly. No sign of a struggle, nor were there any bruises about the dead woman's body. But, in turning over one pillow, he found a lipstick stain in the centre. This stain was the full-bodied impression of two lips and was of the same color as the lipstick used by the dead woman. The impression was so clear that it indicated the pillow had been pressed hard against the mouth. Here was evidence of foul play.

The woman was not identified at the moment, having registered under an assumed name. A box of sedative capsules was found in her effects. The name of the drugstore was obtained from it and the prescription traced to her family physician who was able to supply the missing information. It appeared that the young woman was married but lived apart from her husband whom she met occasionally. The husband was located and confessed to suffocating his wife. A crime solved through vigilance for detail.

(*To be concluded next month*)

The sky is actually colorless. The beautiful colors, which we see in the heavens, are caused by the reflection and refraction of the sun's rays by the infinite number of dust particles scattered throughout the atmosphere.

Public Health Nursing

Camping for Crippled Children

GRETTA M. ROSS

Average reading time — 8 min. 24 sec.

A GENTLEMAN truly interested in child welfare was once invited to visit a camp for crippled children. He accepted but his reply inferred that he was not particularly thrilled by the prospect. He felt that it might be a depressing place—not only for visitors but for the children themselves.

However, he came—he saw—and was conquered! His comment was similar to that of all visitors, who say with surprise and conviction—"How happy all these children are!"

Let us look for the reason. In all camping the general aims stressed are:

1. The development of physical, mental, and spiritual health.
2. Special skills.
3. Love of the out-of-doors.
4. Social adjustment.

If these four aims be important for the normal child, how much more important must they be for the crippled child who, because of his handicap, cannot participate in so many activities taken for granted by the normal child.

So often a crippled child is deprived of real companionship with those of his own age group. His horizon is a narrow one. A camping experience gives him this companionship and widens his horizon. He is surprised to discover that the activities here are the same as those of the camp of which his physically fit pal has been bragging for years. He is thrilled to find that here he can participate in all these activities.

This holiday gives him all these things in abundance: sports, games, arts and crafts, swimming, dramatics,

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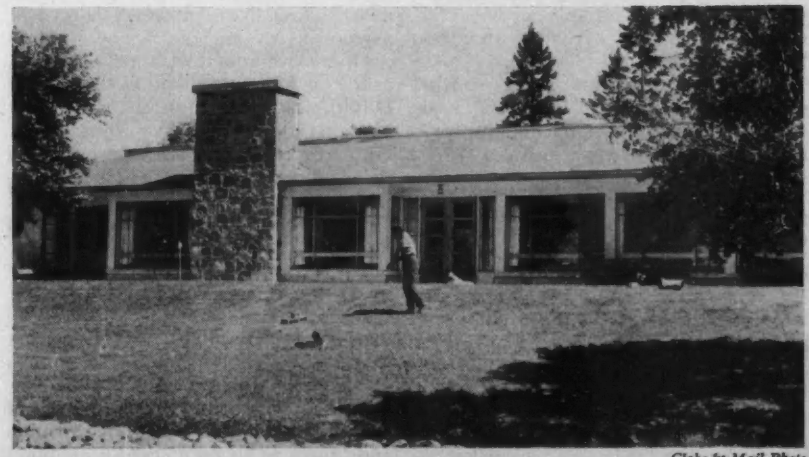

Globe & Mail Photo

Blue Mountain Lodge

music, folk-lore, nature study, campfires, etc. From a program of this kind, the handicapped child benefits greatly but still of greatest importance is his social adjustment.

The Ontario Society for Crippled Children has three camps. "Blue Mountain" on the shore of Georgian Bay, five miles west of Collingwood, Ont., was opened in 1937. It is ideal for the purpose with a wide expanse of water and sand and the ever-changing Blue Mountain in the distance.

"Woodeden," seven miles west of London, was opened in 1946 and is best described by an excerpt from an article written by Elliott Dickinson and published in *Forest and Outdoors* under the title of "Woodeden—Castle of Childhood":

> Straight out of a picture book, a few miles west of the forest city of London, Ont., stands "Woodeden." Characteristic of its lovely name, it is set in the curve of the Oxbo Creek and in the fold of the gentle hills. Nowhere has Nature been so lavish. Unobtrusive and quiet, its beauty is as simple in its appeal as the light and shadow that perpetually fill its generous acres.

Equally beautiful is "Merrywood-on-the-Rideau" on Rideau Lake between Perth and Smiths Falls, Ont., opened in 1948. This large estate, with its green lawns sloping to the water's edge, its maple grove and extensive grounds, provides an ideal location for crippled children.

These three camps serve south-western and eastern Ontario and together make it possible for approximately 450 children to enjoy a three weeks' holiday under ideal conditions.

There are in Ontario many other handicapped children who would benefit from such an experience, and it is hoped that in the not-too-distant future a camp may be established to serve the children in the northern part of the province.

The staff of each of the camps consists of the following personnel:

> Camp director, two nurses, housekeeper, program director, swimming instructor, six voluntary counsellors, arts and crafts instructor, cook and assistant cook, three kitchen counsellors, one kitchen boy, two handy boys, caretaker.

At all camps 4 groups each remain 3 weeks: Boys 5 to 12 years of age and boys 12 to 16; girls 5 to 12 and girls 12 to 18 years. The child accepted may be from one of three groups:

> 1. The crippled child who has no means of obtaining a camp holiday, either because of lack of facilities or finances.
>
> 2. The child who is too crippled to go to any other camp. There may be no financial difficulty in this case.
>
> 3. The child who, for some special reason, such as association with other handicapped children, needs a specialized camp of this kind.

It is most interesting to observe the reactions of children attending camp for the first time. Home-sickness is rarely a problem. It may be accentuated by the weariness of a long trip but it is soon cured by understanding staff and cabin friendships.

Two little friends, six-year-old girls, victims of cerebral palsy, took their first steps at camp as a result of the efforts of two counsellors who, by a little competition, succeeded in stimulating both children to greater efforts. Similarly, an older camper, who had been overprotected all her life, learned to wait upon herself when her cabin friends refused, with the frank comment, "Get it yourself—you're just as good as we are!"

One is reminded of a new camper, a boy of 12, a sad-looking little man. David was a spina bifida with complete paralysis from the waist down. He came from a home where he had received very good care. He was intelligent and realized that the outlook for the future was a gloomy one. On his second day, he cheerily called the nurse with a new note in his voice and said brightly, "Gee, nurse, I'm lucky! I never knew I was lucky till I came to this camp. I might have been just like Bill!" Bill, a cabin pal and a severe athetoid with speech difficulty, told the nurse confidentially how glad he was not to have David's trouble and "have to sit on a cart all his life."

Many instances of this nature are

Turofsky, Toronto

Around the barbecue

seen and some have far-reaching results. One of the most outstanding is that of a charming little girl, a post-polio, who was referred to camp by her orthopedic surgeon. This child's home conditions were good and she had received excellent care. She was exceedingly fond of sports and found herself, after a year, still on a frame unable to walk and with considerable weakness of back and arm muscles.

The future appeared very dark to this "teen-ager" when she arrived at camp. For the first few days she was listless and uncommunicative, taking little interest in her surroundings. A cabin friend—a cerebral palsy with multiple handicaps—was struggling across the beach, when Jane, from her polio cart, said to the nurse, "I guess it's not so bad to be on a cart. I'd hate to be like Esther!"

From that day there appeared a decided change in Jane's attitude. Her appetite improved and she became more interested in the troubles of others and less in her own. This girl came back to camp for several years, at first off her frame only for part-time, using crutches and wearing two leg braces and a back brace. Gradually these were discarded until she walked only with a cane.

Later this girl was able to attend university, graduating in social science. She has a pleasing personality, is well adjusted, and now has a position with a social agency where, due to the understanding gained in her own childhood experience, she will doubtless make a valuable contribution.

A determined effort is made by all members of staff to carry out a program following as closely as possible that of a camp for normal children. One finds the campers ready and keen to participate in all types of activity. They appreciate the attitude of the staff, who consistently stress the positive rather than the negative, encouraging their efforts and praising their accomplishments.

All cannot swim or learn to swim but practically all are taken into the water and enjoy the fun. One sees many of the happy gang being wheeled into the water on carts and even carried in on stretchers.

Campers are divided into groups

such as Hurons, Algonquins, Iroquois, etc., according to age and also degree of disability. This facilitates the ease with which a well-planned and co-ordinated camp program may be carried out.

Qualities of leadership soon become apparent among campers and those so endowed are pleased to be given the opportunity of assisting various members of staff. The severely handicapped boy soon finds a buddy who protects his interests and the slightly handicapped little girl finds another child who becomes her special charge.

With the exception of the enforced period of rest which is not too popular, activities are much the same as those of other camps—carried out with variations and with much of the planning being done by the campers. Baseball and boxing are two main interests of the boys. The boy with the strong arms bats a good ball from his wheel-chair, while his buddy with the good legs does the running for him. Excitement runs high especially among the wheel-chair referees who do not hesitate to stop the game at the least infraction of rules.

The young boxer, who has been coached by the program director, does his best but his opponent shows no mercy. The activities of the world of sport are well known to these lads, quiz programs on sports being a favorite pastime. "Cook-out" suppers are thoroughly enjoyed and, strange as it may seem, "over-nights" with "cook-out" breakfasts were successfully carried out, with quite severely handicapped children, last summer.

Approaching the end of each camp period, the final banquet is an important event, the campers being allowed to plan many of the details. The older boys may decide upon a "Lumbermen's Party," with a menu suitable for a lumber camp. Decorations, place-cards, favors, etc., are made by the children in arts and crafts period. One enters a dining-room which has been transformed into a woodland scene of logs, cedars, etc. Lights are dim, candles in log-holders, small axes, saws, etc., appear as favors. The boy chosen by his pals as the "best all-round camper" acts as chairman. Toasts are proposed by the campers, pennants and shields are presented, speeches are made, and the evening is one long to be remembered by campers and friends privileged to attend.

Campers frequently request a dance even though many of their number may not be able to participate. "Woodeden" is privileged in having several local bands which come to the camp and provide evenings of dance music. Popular music and peppy musicians are two essentials of camp. Singing is heard daily and evening programs always end in a lusty sing-song.

Dramatics are exceedingly important and provide an opportunity for each camper to participate in some way. Days are spent in preparation for these events, the costumes, properties, etc., being made by the children under counsellors' supervision with rehearsals worked in somehow, until the great night finally arrives.

Guests arrive from the nearest centre. The last bit of make-up is applied, the curtain rises, the footlights glitter, and one sees the cast arrayed in all its glory. The audience is amazed and the clapping is loud and long.

Jennie sings from her wheel-chair; Mary with her speech defect proudly speaks her lines. The jokes are really good and the play runs smoothly. Suddenly, something happens to Annie—the bright, little leading lady with the merry eyes. Her leg braces become tangled; she stumbles and falls headlong. Visitors gasp and look aghast at the staff, who sit apparently unmoved. Annie lifts her head—her pals shriek with laughter; Annie chuckles, scrambles up and goes on.

Yes, "The Play Goes On," and that is what we must not forget. Many of the physical handicaps must remain but much can be done to improve the mental attitude. We must not forget that many a kindly meant comment may "cut to the quick." These children do not want pity; they hate it. As Dr. Carlson has said in

his book "Born That Way," the crippled child prefers to be laughed at rather than be pitied, and at camp we see many evidences of the truth of this statement.

May I quote from a letter of a young staff member, following his first summer at camp:

> For the first time, I fully realized that what is of real worth in a person is not his appearance, it is not his physical capabilities—it is the influencing of people. What really counts is that deep and abiding thing called character. They have it and I am proud to count them as my friends.

The Battle Against Leprosy

HELEN AST

Average reading time — 5 min. 24 sec.

To all those infected with leprosy, whose number is estimated at seven million, the tremendous progress recorded in the fields of medical and pharmaceutical research has brought new hope. Since approximately a million-and-a-half of these lepers live in Commonwealth territories (including India the number was formerly about three million) it is natural that Britain should have made an outstanding contribution to this achievement. Intensive research, comprising experiments with new drugs, has been carried out in both Britain and overseas. With a view to preventing the spread of the disease, much was done on the spot to enlighten and educate the native population. Steps were taken to protect the children from infection, to improve living conditions generally, and to encourage the patients to make voluntary use of medical facilities provided.

When Sir Leonard Rogers, a member of the Indian Medical Service, began to use injections of chaulmoogra, or hypnocarpus oil, the only known method of treating the affliction was the internal use of that oil. The injections were to a large extent effective. A decisive improvement did not occur until the American drugs, Promin and Diasone, were developed. These were followed by another preparation belonging to the group of the sulfone compounds: Sulfatrone. In the short time since its introduction, this drug has proved invaluable in the treatment of malignant cases, more especially because of its less harmful side-effects on the general condition of the patient. It is, therefore, now almost the only drug used in the Commonwealth areas concerned.

So much for the drugs. The best of these cannot be relied upon to effect a complete cure and thus be instrumental in eradicating the scourge, unless the treatment is organized, in accordance with modern ideas, on a humanitarian basis. The many experiments undertaken have demonstrated that, as in the treatment of tuberculosis, the chances of success are small if the segregation of the patients is enforced without taking into account the psychological factor. Work, pastimes, and entertainment are, therefore, provided for the patients: sports, games, music, books and, for children, schools. Wherever possible, without the risk of infection to others, the patients are even permitted to visit their families. Agricultural settlements occupied by lepers are no longer something new. The inhabitants work in the fields and in the garden, earning their keep. In some cases they have built whole villages, in which the dwellings are cleaner and more comfortable than the homes they have been compelled to leave. In a word, the inhabitants of these settlements go about their work in the knowledge that they are not outcasts, but useful members of society—a state of mind without which there could be no hope of a permanent cure.

An exceptionally optimistic report was issued recently by the leprosarium in Mahaica, British Guiana, to the effect that, in ten years' time, the scourge will probably have ceased to exist in that territory. Thanks to the cooperation of an enlightened native population, the establishment has acquired

(*Turn to page 561*)

The United Kingdom Information Office provided the material contained in this article.

Private Nursing

A Study of Congenital Heart Disease by Cardiac Catheterization*

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P. P. HAUCH, M.D. (*c*), *and* J. A. LEWIS, M.D. (*d*)

Average reading time — 18 min. 24 sec.

THE PROCEDURE of cardiac catheterization is being adopted widely, both as an aid in the diagnosis of congenital heart disease[1, 2] and in the study of circulatory dynamics. Although Forsman demonstrated the feasibility of catheterization of the right auricle through a peripheral vein, it was not until the publication in 1940 of the cardio-dynamic studies by Cournand and Ranges[3] that the procedure was shown to be practical and safe. It is fitting that the first publication of the study and diagnosis of congenital heart disease by cardiac catheterization in Canada should emanate from Montreal.

It was felt that this method was applicable for the diagnosis of congenital heart disease being encountered in the Heart Clinic and on the wards of Westminster Hospital. It was likewise felt that knowledge of functional capacity and prognosis of certain types of congenital heart disease could be increased, since these men had fought in a war and in the majority of instances were now gainfully employed.

Our technique of catheterization is similar to that described by Johnson and associates.[1] Preliminary sedation of morphine gr. ¼ and nembutal gr. 3 were administered routinely one hour before the procedure was commenced. A cut-down was made on the left median basilic vein and a Cournand catheter was introduced. Heparinized saline solution was continuously infused during the procedure of a concentration of 10,000 units (1 ampoule per litre of saline). By a three-way stop-cock this was connected with a saline manometer, the zero pressure point being taken as 4 cm. below the xiphoid with the patient in the dorsal recumbent position. This arrangement was suggested by Dr. D. W. B. Johnston and appears to approximate the method of McMichael and associates.[3]

The catheter was advanced under fluoroscopic control and in each instance an effort was made to catheterize the pulmonary artery. In our first four patients, a size No. 10 Cournand catheter was used. It was technically impossible to catheterize the pulmonary artery with this catheter. In all subsequent cases a No. 8 catheter was used and pulmonary artery catheterization was rendered relatively easy. We have not found the use of a curved tip catheter to be necessary, although it may make intra-cardiac exploration easier. Pressures have been taken from the peripheral pulmonary artery circulation; the main pulmonary

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* This study was carried out in the Heart Clinic and wards of the Westminster Hospital, Department of Veterans Affairs, London, Ont.

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artery; each chamber of the heart entered and the superior vena cava only. Blood samples have been withdrawn from these sites, placed under oil and the blood oxygen content determined by the method of Roughton and Scholander.[4] In two cases the results have been checked with the Van Slyke by one of us (N.J.E.) with close agreement throughout between the results. We have felt that with suitable correction of temperature and barometric readings this method is suitable for our studies.

This series comprises 20 cases. Congenital heart disease was suspected but not verified in 9 instances. Of the remainder, septal defects were found in 5; ductus arteriosus in 2, suspected in 2 more; Eisenmenger's complex in one and in one a wandering pacemaker without other congenital abnormalities.

An unusual finding in this series is the persistence of the left superior vena cava which was encountered three times in these 20 cases. This defect, in our experience, has never occurred alone but was associated in one with trilocular heart; in 2 with ductus arteriosus. In one case a double kidney was present. It is likewise of interest that there were but two cases with congenital heart defects which showed a single defect to be present. One of these was ductus arteriosus, the other an interauricular septal defect. This bears out the well established fact that congenital defects in the heart are usually multiple. In one very unusual instance (*see Fig. 4*) a right pulmonary vein was found to empty into the right auricle or into the superior vena cava. It was of interest that in this case septal defect was clinically suspected and that catheterization bore out the impression of arterialization of blood in the right chambers of the heart.

Three interauricular septal defects have been studied. In only one instance[5] was radiographic appearance characteristic. Another presented an associated interventricular septal defect. In the third, a ductus arteriosus was present. However, interauricular septal defect, functionally patent, may be present without producing the characteristic x-ray silhouette.[6]

Burwell[7] found the blood aspirated from a peripheral branch of the pulmonary artery to be considerably oxygen enriched. We have verified this observation repeatedly in the absence of ductus arteriosus. Although we have figures for but three examples of persistent ductus arteriosus, it was found that the blood aspirated from the peripheral branch of the pulmonary artery was not richer in oxygen than that aspirated from the main branch of the pulmonary artery. We submit this observation as one requiring further study, since it would suggest certain attributes in the normal pulmonary circulation. Our explanation of this phenomenon is that with respiration there is normally an ebb and flow in the pulmonary circulation. The presence of ductus arteriosus, introducing as it does the high systemic pressure into the pulmonary circulation, renders the blood flow through the lung continuous. This further suggests "central origin," for

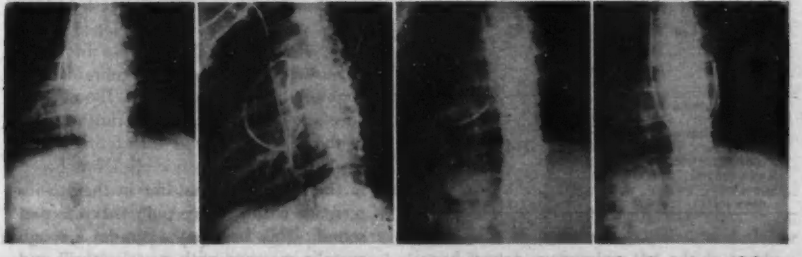

Fig. 1.—(a) Catheter tip in left posterior cardiac pulmonary artery, having entered heart through left superior vena cava—right anterior oblique position. (b) Same as (a), showing catheter in the posterior pulmonary vein. (c) Catheter in right ventricular apex with catheter looped up into right superior vena cava. (d) Same as (c) following straightening out of the loop

some at least, of the cyanosis seen after exercise in the presence of ductus arteriosus.

Case 1

(Patent ductus arteriosus: persistent left superior vena cava)

This male, aged 26, had led an active life without illness of any moment. The presence of a patent ductus arteriosus was diagnosed in 1941. He was permitted to do heavy duty as a stretcher bearer in combat. He developed dyspnea, dull mid-thoracic pain, and was unable to carry on. He was demobilized from the army and was able to perform less strenuous duties. Upon returning to work as a carpenter, he noted recurrence of retrosternal, dull pain, and exertional dyspnea with any form of strenuous exertion.

Examination revealed a small, well-nourished male without cyanosis or clubbing. There is congenital absence of the nail on both 5th fingers and both 5th toes. Radiologically, frontal sinuses are absent. The resting pulse was 80 with a fair exercise tolerance. Blood pressure 110/70 with no change upon exercise. The heart was normal in size. A thrill was palpable in the 2nd left interspace. A typical "machinery" murmur was heard over this area, transmitted over the precordium and toward the left shoulder, and heard with grade 2 intensity at the level of the spine of the left scapula. The lung fields were clear and there was no enlargement of the liver or ankle edema.

Teleo-roentgenogram showed a filling in of the cardiac waist without hilar dance but with prominence of the main pulmonary vessels. The electrocardiogram showed no axis deviation or conduction disturbance. Cardiac catheterization result is shown in Table I:

Table I

	Pressure	*Oscillation*	*Oxygen*
Left pulmonary artery.....	12.0 cm.	1 mm.	17.0 vol. %
Main pulmonary artery...	11.5 cm.	1 mm.	17.0 vol. %
Right ventricle.	9.5 cm.	3 mm.	6.9 vol. %
Right auricle...	1.0 cm.	1 mm.	12.7 vol. %
Superior vena cava left.....	4.0 cm.	...	15.8 vol. %

It is noted that the blood in the periphery of the left pulmonary artery has the same oxygen content as has the blood in the main pulmonary artery. This is markedly increased over the concentration in the right ventricle, suggesting that the ductus is large. It may be pointed out here, that upon this observation we postulate the theory that the presence of a patent ductus arteriosus produces pronounced acceleration in the pulmonary circulation and loss of the normal reflux. The oxygen saturations from the left superior vena cava are of interest. In this particular case the catheter passed through the left superior vena cava only on deep inspiration. Anatomically it should be remembered that the catheter must pass through the coronary sinus when traversing the left superior vena cava to enter the right auricle.[8] It is possible that the values called "right auricle" may represent blood obtained from the coronary sinus itself or from the right auricle immediately adjacent to the entrance of the coronary sinus. This would account for the higher oxygen concentrations obtained in the venous blood and the right auricle than that from the right ventricle.

This man's ductus arteriosus was successfully ligated by Dr. A. J. Grace. Further observations will be made to determine the alteration in pulmonary hemodynamics.

Case 2

(Eisenmenger Complex)

This 28-year-old male had been a Japanese prisoner-of-war and was examined in our Heart Clinic in October, 1946. He had not been a blue baby. His development was quite normal. There have been no significant illnesses apart from treatment for lues in 1943. He is unable to do light work at the present time because of exertional dyspnea; left thoracic oppression and weakness in the legs.

He was a thin, poorly developed, small male with flushed cheeks, nose and ears; cyanosis of the mucous membranes and slight clubbing of the fingers. Blood pressure was 130/94; pulse 84. Transverse lie of the heart was noted with filling of the cardiac waist. A systolic click was heard in the left parasternal line in the 4th interspace with a sharp pulmonary second sound. This becomes a grade 3 rough systolic murmur with systolic thrill and a diastolic shock. After exercise a protodiastolic gallop rhythm developed at the apex. The ocular fundi revealed full

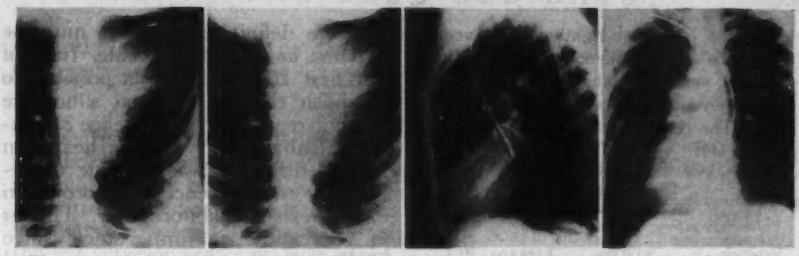

Fig. 2.—(a) Catheter in apical portion of right ventricle, which appeared to be enlarged longitudinally. (b) Catheter tip in region of ampullary part of right ventricle, lying adjacent to interventricular septum. (c) Subsequent examination several months later—catheter tip in a right pulmonary vein, having passed through an interauricular septal defect. (d) Same as (c)—lateral position.

veins. The lung fields were clear and liver not enlarged. There was no ankle edema. The x-ray showed enlarged heart with a prominent pulmonary conus.

The electrocardiogram showed right axis deviation of high degree with S-T segment depression and a sharply negative T in Lead CR4. The urinalysis was normal; hematocrit 63.1 and Kahn negative.

TABLE II

	Pressure	*Oscillation*	*Oxygen*
Pulmonary artery	.....	...	....
Right ventricle...	4.5 cm. (apex)	2 mm.	16.0
Left ventricle....	55.0 cm.*	20 mm.	21.1
Right auricle.....	3.5 cm.	3 mm.	16.9
Superior vena cava.....	2.5 cm.	3 mm.	13.9

*(or at interventricular septal defect)

CASE 3

(*Triloculare biatrium*)

This nine-year old girl, seen through the courtesy of Drs. Little, Bartram and McLachlin, exhibited well-marked cyanosis and clubbing. Patient complained of slight limitation of exercise tolerance in extremes but has been surprisingly active for one so cyanosed. It may be of significance that she is repeating Grade 3 at school.

Clinical examination revealed a heart at the upper limits of normal in size with blood pressure 110/82; a pulse of 90 and an impaired exercise tolerance. No murmurs were elicited. Auscultation revealed a double first sound at the apex. Teleoroentgenogram revealed a globular heart with a broad superior mediastinum. The electrocardiogram showed low voltage with a broad large P and a diphasic T in Lead CR4. Cardiac catheterization was performed under nembutal sedation. The catheter met an obstruction in the root of the neck and finally passed down a persistent left superior vena cava. Further progress of the catheter resulted in the production of a large coil in the right auricle and ejection of the catheter

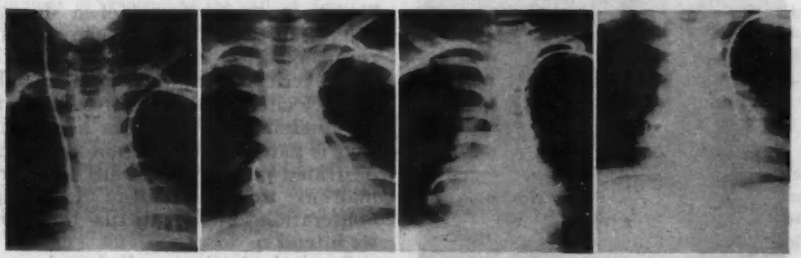

Fig. 3.—(a) The catheter enters the heart through a persistent left superior vena cava, traversing the large displaced right auricle across the mid-line and enters the right superior vena cava. (b) Catheter tip lying in the region of the left main pulmonary artery. (c) Catheter tip in left ventricular apex (slight left anterior oblique rotation). (d) Catheter tip in right main pulmonary vein to lower lobe, having passed through left ventricle, mitral valve, and main pulmonary vein.

into the persistent right superior vena cava. In all, the pulmonary artery, the inferior vena cava, the pulmonary vein, and the ventricular cavity were catheterized. The results obtained are shown in Table III:

TABLE III

	Pressure	*Oscillation*	*Oxygen*
Pulmonary artery	6.0 cm.	1 cm.	15.5
Pulmonary vein..	3.0 cm.	...	25.8
Ventricle.....	61.0 cm.	2 cm.	20.7
Right auricle.....	2.5 cm.	...	15.7
Superior vena cava (left) ..	1.5 cm.	...	15.4

But one question remains—that being the route traversed by the catheter in reaching the pulmonary vein, since technically the pulmonary vein was entered while searching for the aorta along the left cardiac silhouette. It appeared that the catheter passed in a retrograde direction through the mitral valve. The fact that the blood from the right atrium is of identical value with venous blood further supports the opinion that the catheter could not have traversed an interauricular septal defect.

Diagnosis—Cor triloculare biatrium. It is of interest in this patient that the futility of surgery would appear established.

DISCUSSION

It has been established that cardiac catheterization is a useful method of aiding in the localization of congenital heart defects. The procedure is not one attended by risk of complication or sequelae. It is particularly useful where a definitive diagnosis must be reached as soon as possible. In 7 of our first 20 cases, it was possible to establish that an unusual silhouette did not represent the presence of congenital abnormality of the heart. In several others it was possible to determine the presence of more than one co-existing abnormality. This is of great practical importance, since in Case 1 the surgeon was warned that a large left superior vena cava would be encountered. This was found lying across the ductus arteriosus and associated with other venous abnormalities at the operative site. In our opinion, however, it is not possible to estimate with accuracy the size of the ductus that will be encountered by pressure or blood oxygen determinations. A patient with persistent ductus arteriosus, ligated in the same week as Case 1, showed only 1.4 volumes % increase in the pulmonary artery blood oxygen, as compared with the right ventricle and an enormous increase in the pulmonary artery pressure, which measured 117 cm. of saline. In this case the ductus again was found to be of almost the same diameter as the aorta. We offer no explanation for this discrepancy.

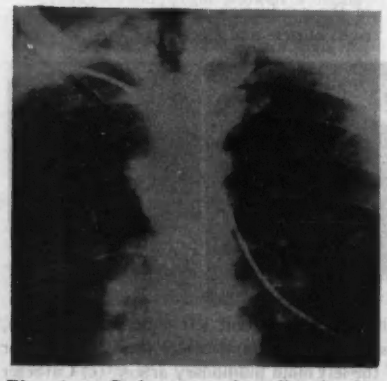

Fig. 4. — Catheter passing directly from superior vena cava into a pulmonary or bronchial vein.

It is worth noting that the Bohn test has been of no assistance to us in the diagnosis of patency of the ductus arteriosus. We believe that the blood oxygen taken from the peripheral pulmonary artery circulation is identical with that in the main pulmonary artery in the presence of a ductus arteriosus. We further believe that this represents evidence to indicate the severity of the alteration in pulmonary circulation which results from the presence of a ductus arteriosus that is patent. We have not yet demonstrated a reversal toward the normal in this mechanism following obliteration of the ductus but this we intend to do.

Surgical selection can be based upon the information derived from cardiac catheterization. Cases 2 and 3 are examples of congenital heart lesions in whom the results of catheterization indicated that surgical procedures

presently known would not benefit these patients.

Conclusion

Twenty patients, in whom the presence of congenital cardiac abnormalities were suspected, were subjected to cardiac catheterization. The unusual frequency of persistence of the left superior vena cava was noted. It occurred in 3 of the first 20 patients. Where discovered, it was invariably associated with other congenital defects. The usefulness of this procedure in demonstrating unsuspected abnormalities and in selecting patients who might be benefitted by surgery is clearly borne out. The blood oxygen determination by the method of Roughton and Scholander has been found satisfactory in our hands.

References

1. Johnson, A. L., Wollin, D. G., and Ross, J. B.: *Can. M. A. J.*, 56: 249, 1947.
   Keith, J. D.: *Can. M. A. J.*, 58: 247, 1948.
2. Cournand, A. and Ranges, H. A.: *Proc. Soc. Exp. Biol. & Med.*, 46: 462, 1941.
3. McMichael, J. and Sharpey-Schaefer, E. P.: *Lancet*, 246: 489, 1944.
4. Roughton, F. J. W. and Scholander, P. F.: *J. Biol. Chem.*, 148: 541, 1943.
5. Banghart, A. W. and Lewis, J. A.: *Can. M. A. J.*, 58: 605, 1948.
6. Ash, R.: In Stroud, W. B., Diagnosis and Treatment of Diseases of the Cardiovascular System. F. A. Davis Co., 3rd Ed. 1946.
7. Burwell, C. J. and Dexter, L.: Modern Concepts of Cardiovascular Disease, 16: 4, 1947.
8. Grant, J. C. B.: An Atlas of Anatomy, Williams & Wilkins, 263: Fig. 313, 1st Ed. 1945.

In the Good Old Days

(The Canadian Nurse, July 1910)

"Our profession stands, or ought to stand, for the highest and the best, and it is the sacred duty of every woman on graduating to pledge herself to do her duty conscientiously and to the best of her ability and at all times to uphold the dignity and honor of her profession. Now, it hardly seems to me as if a nurse were upholding the honor of her profession when, without adequate reason, she declines to respond to the call of duty, as, for instance, refusing to accept night calls . . . or by declaring that she would not accept a call between certain hours and in certain localities. These instances have occurred, I am sorry to say, and the nurses to whom I allude are not the older graduates, worn out from having given many years of good work to their profession, but young nurses—the products of the latest and most advanced training."

* * *

"Possibly the trouble with young nurses is . . . that the spirit of the age seems to be creeping a little into the profession—'Get as much as you can and give as little as you can.' If we can bring into our minds the fact that we are training future nurses, we may be able to inculcate some principles into them so that in the next generation or two nurses will have a clearer idea of their obligation to the public, to their hospital, and to the profession."

* * *

In 1910, there were 1,600 copies of *The Canadian Nurse* being printed each month with a paid-up subscription list of 1,200. In 1950, forty years later, there are approximately 11,000 copies of the *Journal* printed each month, with a list of some 10,800 subscribers.

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"There was a niece of a friend of mine who goes to the church school here. She passes the hospital daily and is very much interested in it. She keeps talking to her governess of what she is going to do: she is going to be a nurse. The governess, anxious to make the most of an opportunity, said, 'You must be a very good little girl and study hard to be a nurse.' The little girl pondered and said, 'Oh, do nurses have to study? Well, I think I'll just be an ordinary mother then.'"

Aux Infirmières Canadiennes-Françaises

Les Aides dans l'Equipe en Nursing

ANNE HAHN LINDBLAD *et* MILDRED STRUVE

Average reading time — 14 min. 24 sec.

CET ARTICLE n'est pas publié dans le but de discuter les avantages ou les difficultés que peut présenter le service des non-professionnelles ou aides-infirmières dans un hôpital. Le comité d'enquête de la National League of Nursing Education, dans un article "Study of Nursing Service," a déjà résumé les principaux problèmes qui découlent de l'organisation de ce système dans les hôpitaux américains.

Nous essaierons de décrire ici l'organisation d'un programme qui, après avoir été mis à l'essai durant une période de deux ans dans certains départements, et quelques mois dans d'autres, semble donner un résultat satisfaisant.

Le point culminant de ce système est de dégager les infirmières graduées et étudiantes de la responsabilité des soins d'ordre matériel et purement technique, afin qu'elles puissent concentrer leur énergie vers un travail plus scientifique, assurer plus de confort au malade, en même temps lui donner plus de connaissance de l'hygiène préventive.

L'hôpital, dont il est ici question, est un hôpital d'une capacité de 1,000 lits, reparti en salles, chambres semi-privées et privées. Organisé en service spécialisé de médecine, chirurgie, pédiatrie, obstétrique, psychiatrie, urologie, gynécologie, ophtalmologie, cet hôpital dispose encore d'un service de dispensaires. Bien qu'on y emploie des aides ou filles de salles depuis une vingtaine d'années, jamais elles n'ont contribué au service immédiat des patients, comme nous le voyons aujourd'hui. Leur rôle était limité aux travaux suivants: Faire les lits (fermés et ouverts), mettre de l'ordre dans les effets personnels des malades, porter les plateaux, ranger le linge dans les armoires, conduire les patients aux cliniques, etc.; la plupart de ces travaux, que l'on aurait dû faire exécuter par des servantes, étaient très fréquemment confiés aux étudiantes. Les aides n'avaient pas de qualifications spéciales; leur salaire était minime et on ne leur donnait aucun enseignement, ni aucune formation. Il appartenait à la garde en chef du département de leur assigner leur part de travail.

Les services que les bénévoles de la Croix-Rouge rendirent pendant la guerre démontrèrent que ces jeunes filles, en travaillant sous la surveillance immédiate de graduées, accomplissaient un travail très appréciable.

De plus, il a été également prouvé que cette catégorie de jeunes filles, malgré leur excellente instruction et leur personnalité distinguée, requéraient un entraînement et une surveillance adéquate.

PROJET D'UN PROGRAMME

A la lumière de ces faits, un comité fut formé parmi le personnel du nursing afin d'étudier la situation, d'apporter des suggestions, et d'établir un programme d'entraînement des

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aides non-professionnelles. Ces employées devaient remplir autant que possible les tâches des aides bénévoles de la Croix-Rouge et améliorer ainsi la qualité du service des malades d'une façon notable.

Pour réaliser notre projet, nous avons choisi un petit département dont le personnel est composé d'infirmières graduées où le genre de service est régulier et le service n'est interrompu que pour donner aux aides l'enseignement de groupe. Nous avons également décidé que cet enseignement serait une activité départementale—i.e., propre à chaque milieu, de sorte qu'une aide formée au travail d'un département ne serait pas transférée dans un autre.

Toutes les activités furent déterminées et classées en trois catégories:

1. Les activités en rapport avec le soin du malade et accomplies par des filles de salles non entraînées, des aides de salles ou infirmiers.
2. Les activités non professionnelles accomplies par les servantes et commissionnaires entraînés.
3. Les activités accomplies par les infirmières seulement, soit étudiantes, soit graduées.

Une fois ces fonctions bien définies, il parut évident qu'on obtiendrait un meilleur rendement en éliminant le groupe d'aspirantes et en lui substituant des employées mieux qualifiées, qui auraient suivi un programme organisé et surveillé.

La plupart des travaux accomplis par les aspirantes furent assignés à des servantes et commissionnaires. Après quoi, on fit une nouvelle énumération des soins en rapport avec le malade, notant que le plus grand nombre de ces traitements étaient donnés par des infirmières. De cette liste, nous avons jugé quelle part de travail pourrait être remplie par les employées non-professionnelles, bien que qualifiées, travaillant sous la surveillance directe d'infirmières professionnelles, tout en tenant compte de la sécurité et du bien-être du patient.

Les conditions essentielles du succès dans la réalisation de ce projet furent:

1. De déterminer les aptitudes, de reconnaître le statut et le titre officiel qui devaient distinguer les aides.
2. D'établir une échelle de salaires.
3. De choisir un uniforme attrayant et convenable — de disposer d'un vestiaire pourvu de toutes les commodités requises.

Un autre facteur de succès fut d'organiser un programme d'enseignement dans lequel a été confiée une part de direction et de surveillance aux infirmières professionnelles. Faire accepter ce plan aux infirmières et obtenir leur collaboration étaient aussi d'une importance primordiale. De plus, il fallait considérer un moyen pour développer chez les aides une mentalité — i.e., leur faire comprendre l'importance de leur coopération dans l'équipe du nursing, le sens de la responsabilité et de l'honneur qu'elles devaient apporter dans l'exercice de leurs devoirs.

Dès que tous ces plans d'essai furent tracés, des conférences individuelles et de groupe furent tenues avec le conseil administratif de l'hôpital, les chefs médicaux, et les membres du personnel.

Les raisons de ces conférences étaient d'expliquer le but à poursuivre et les résultats désirés, de mettre en lumière les divers aspects du programme, de considérer les suggestions, et de soumettre les résolutions à l'approbation de la direction. Ces conférences ont aidé à obtenir l'appui des groupes. Le fait d'avoir discuté nos plans en détail avant même de les avoir rédigés, nous donna l'impression d'avoir gagné la confiance et la collaboration de tous et de chacun.

Conditions d'Admission

Voici les conditions que l'on a établies à titre d'essai:

Qualifications et choix des aspirantes —

1. *Degré d'instruction:* Diplôme d'une école supérieure.
2. *Age requis:* 18 à 30 ans.
3. *Statut social:* Célibataire de préférence, quoique des femmes mariées sans enfants pouvaient être acceptées.
4. *Nationalité:* Aucune distinction.

Conditions d'Engagement

1. *Salaire:* Tarif à l'heure, assez élevé

pour attirer les candidates, avec promesse d'augmentation à des intervalles réguliers si le service est satisfaisant. Le salaire doit couvrir la première journée d'entraînement.

2. *Vacance:* Une rémunération en maladie et congé.

3. *Heure:* Une semaine de 48 heures avec une journée complète de congé.

4. *Un examen médical:* Préliminaire et soins médicaux gratuits.

5. *Uniforme:* Un uniforme gris, attrayant, en une pièce, avec poignets et collets blancs, bas beige et souliers foncés, noirs, blancs ou bruns, permettant de distinguer les aides infirmières des autres employées.

Orientation

Une conférence préliminaire, traitant de l'application des règlements du personnel et des conditions d'engagement, est donnée aux candidates.

A cette conférence, l'infirmière en chef explique également les activités du service, ce que signifie être membre du personnel d'un hôpital, les responsabilités et la satisfaction que l'on éprouve au service des patients, les avantages d'un service de santé pour le personnel, la nécessité de se conformer à la discipline de la bonne tenue, du port de l'uniforme; enfin le programme d'entraînement, d'enseignement, et de surveillance. Ensuite, la candidate remplit des formules d'application; on fixe l'heure de l'examen médical et de la photo d'identification; et là encore on trouve l'occasion de donner de plus amples informations.

Expérience et Enseignement

Vu que les aides doivent recevoir leur entraînement dans le département où elles sont en service, il convient, dès le début, de les assigner à leur département respectif. On ne peut assez démontrer l'importance d'un programme d'entraînement bien rédigé, d'un choix d'instructrices qualifiées, ayant une grande compréhension des principes sur lesquels repose l'organisation de ce programme et du but à atteindre, comme des moyens à prendre pour obtenir une surveillance suffisante.

Les instructrices de la technique du soin des malades, les instructrices de l'enseignement clinique et les surveillantes de ce service ont été démises de leurs fonctions antérieures afin de se consacrer à plein temps à l'enseignement et à la surveillance des aides.

Ces instructrices firent connaître le programme au personnel infirmier des salles et leur donna des directives sur la répartition du service du nursing, afin que le travail fait par les aides puisse être des plus pratique. Nous avons appuyé fortement sur la nécessité d'une surveillance constante de tous les groupes d'infirmières travaillant avec ces aides.

Après une période d'essai, les résultats furent évalués. Se basant sur l'expérience acquise, des projets furent étudiés pour élaborer le programme des aides, afin de rendre leur service plus actif. Ce programme comprend des soins spéciaux en même temps que l'organisation du service du nursing avec des infirmières graduées et étudiantes, ces dernières en service de rotation.

L'emploi des filles de salles non formées fut discontinué. Quelques-unes, ayant fait preuve d'aptitudes et de qualifications, furent promues à la classe d'aides pour y suivre le programme au complet. Les autres eurent l'opportunité d'entrer dans la catégorie des servantes de divers départements, selon l'entente bien définie que, d'après l'élaboration du programme des aides, le groupe des filles de salles serait éliminé.

Heureusement, dans la plupart des cas, ces jeunes filles furent placées à la satisfaction générale.

Le Travail d'Equipe

Il est important que tout le personnel infirmier comprenne très bien la place des aides dans l'équipe du nursing — i.e., le rôle d'une infirmière professionnelle, graduée ou étudiante, et celui d'une aide.

L'infirmière en chef du département est la seule responsable des fonctions des aides infirmières lorsque celles-ci ont complété leur période de formation. La part de surveillance que l'infirmière en chef délègue à une in-

firmière en service avec une aide varie selon l'expérience de chacune dans le travail d'équipe et le genre de patients qu'elles ont à soigner ensemble.

Dans plusieurs occasions, nous avons eu des preuves qu'il était avantageux de placer dans les mêmes services des grands malades et des convalescents; dans ce cas, l'infirmière confiait aux aides le soins général des convalescents; elle tenait compte avec ces dernières, des besoins particuliers de chacun, se réservant les traitements et médicaments de tout le groupe ainsi que le soin des grands malades. En d'autres circonstances, l'infirmière et l'aide étaient assignées aux mêmes malades, travaillant ensemble auprès du même patient, donnant les soins avec beaucoup plus de rapidité et moins d'efforts pour le patient.

Quoique la répartition des soins particuliers des patients soit faite dans tous les départements de l'hôpital, il fut démontré que les aides donnaient un meilleur rendement lorsqu'elles exécutaient certains travaux de routine tels que: mesurer et inscrire le dosage des ingestas, préparer les repas des patients, servir les plateaux, prendre la température.

Que l'aide travaille directement avec une infirmière ou qu'elle accomplisse certaines tâches de routine, elle doit toujours recevoir des instructions précises sous la direction et surveillance constante de l'infirmière. Les étudiantes les plus avancées de même que les graduées ont été choisies pour faire partie du personnel de l'équipe du nursing. Elles doivent apprendre à se servir des aides non-professionnelles, et une fois graduées, capables de répartir les soins des patients avec une entière compréhension de leurs propres responsabilités.

Nombre d'Aides en Rapport avec Celui des Infirmières

Le nombre d'aides requis pour donner un service satisfaisant dans un département varie. Comme notre personnel diplômé n'a pas été régulier, il nous a été impossible de faire des études adéquates sur le nombre d'aides en rapport avec celui des infirmières. Toutefois, nous avons une idée du chiffre approximatif. Dans un département très actif, nous avons constaté que l'infirmière pouvait diriger plus qu'une aide. Là, où il y a un plus grand nombre de convalescents ou patients chroniques, la situation serait sans doute modifiée.

Dans un service de médecine de 28 lits, cinq aides infirmières dont deux en service de jour, une durant la soirée, une en service de nuit, et une autre pour suppléer aux aides en congé, semblent un nombre suffisant dans les salles des hommes; dans les salles des femmes, on exige une aide de plus en service de jour. Notons que les salles des hommes ont un service d'infirmiers de 24 heures continues.

En se basant sur un principe semblable, signalons que l'organisation d'un service de nursing, pour qu'elle soit satisfaisante tant au point de vue du malade que des aides, doit prévoir une rotation régulière du service de jour, du soir, et de la nuit, avec les cédules affichées à l'avance.

Ce plan de rotation est expliqué aux candidates en même temps que les conditions d'engagement. On affiche également le temps alloué pour les congés et les journées libres régulières. Le temps supplémentaire que l'on consacre à préparer ces cédules est largement dédommagé par la satisfaction qu'en éprouve les aides. En diverses occasions le personnel infirmier en chef convoque les aides afin de permettre à ces dernières de discuter leurs problèmes, d'exposer leurs griefs, et de donner leurs suggestions. De ces assemblées de groupe résultent des relations amicales entre les dirigeantes et les aides et une meilleure compréhension des responsabilités du service des malades.

(*Le suite au prochain numéro*)

Health is indeed a precious thing, to recover and preserve which we undergo any misery, drink bitter potions, freely give our goods.—Robert Burton

Institutional Nursing

Auxiliary Workers in Hospitals

HELEN M. KING

Average reading time — 11 min. 12 sec.

THE FACT THAT the subject of auxiliary personnel on the wards appears in nursing and hospital magazines so often and is a topic of discussion at many conventions points to two facts. First, auxiliary nursing personnel is now a recognized part of the medical team. Second, hospitals and the nursing world are not entirely satisfied with the contribution to, or the preparation for, the work of the average nurse aide.

At a staff conference of supervisors and head nurses the shortage of staff was being discussed. One head nurse said, "I find nurse aides very helpful—the patients like them. If you assign them their duties and keep them happy, they are of great assistance on the ward." She had grasped the important points in the utilization of nurse aides—that patients like them; that nurse aides need and must have direction; that their contribution to nursing must be accepted and appreciated to make them happy and contented; and that what they can accomplish is invaluable on a busy ward. A few years ago the average head nurse resented the nurse aide. Her usual comment was that she was not much help. Now, if she has an experienced aide on her ward, she does not care to part with her. This is a significant change of attitude forced on us by the shortage of nurses.

The increased demand for hospitalization requires far more professional nurses than are now available for institutional nursing. Hospitals are not in a financial position to employ sufficient graduate nurses for all the routine bedside care, even if they were available. From an economic viewpoint, it seems ridiculous to use expensively trained people to carry out purely routine tasks which less skilled people can, under supervision, perform very satisfactorily. Miss Lucile Petry, chief of the Division of Nursing, U.S. Public Health Service, has said:

> I think I am typical of many professional nurses who, first, with resistance and reluctance and then with regret, came to understand that professional nurses could not do everything for the patient . . . We know that we want expert care for patients . . . and so, even as we divide activities, we plan for coordination of activities into a unity of total care.

The administrative body of a hospital is concerned with providing safe and satisfying care of the sick. The average patient is not concerned with the up-to-date equipment the hospital provides but with the personal attention he receives. He wants his call-light answered promptly and his requests fulfilled. Most complaints which come to the supervisor's office relate to minor matters—call-bells not answered promptly; linen not changed; delay with commodities required—all services which do not require a high degree of training to perform. In a survey made in a hospital in the United States, it was found that 90 per cent of a patient's calls could be answered by ward personnel other than the professional nurse. These many personal services contribute much to the comfort and peace of mind of the patient. Patients have accepted the nurse aide very well and speak well of her, yet in times of

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distress and anxiety it is still the graduate nurse they ask to see. In any emergency, it is recognized that the professional nurse is essential.

The fluctuating demands of a general hospital make it very difficult to estimate ahead of time what staff one will require. When a peak load is suddenly encountered, it adds to the confusion if a number of new nurse aides have to be added to the staff, all of whom have varying backgrounds of experience and training and who know nothing of the routine of the wards. Moreover, when one requires nurse aides in a hurry, the labor market seems completely empty of suitable people. The solution is in the operation of a school where nurse aide students all receive a prescribed training and from which a hospital can employ reliable workers. Repeated turnover of any type of staff is a very expensive operation and the time and work it involves is something which cannot be ignored.

An experiment was tried, with the cooperation of our teaching department, to train nurse aides speedily for summer vacation relief. The rapidity with which these girls became of value was most satisfying, both to the teachers and the wards. They were taught the theory and given the practical demonstrations in the classroom in small groups. Then they were taken to the wards and allowed to carry out the procedures in actual situations under supervision. They were assimilated rapidly as members of staff and were of real assistance from the first day. This is on-the-job training which has great value.

Schools for nurses aides have been in operation for some time on this continent. One such school has been operated for three years in Vancouver. The candidates received three months' theory and practice in the school followed by eight months' experience in various types of nursing in the different hospitals. There was difficulty in arranging with the hospitals for the necessary ward experience, since budgets had to be adjusted to meet the salaries of these students who were paid on a different basis from the regular nurse aides. In addition, the number of students fluctuated and the hospitals could not always rely on a uniform number at each rotation. The coordinating supervisor for the practical experience from the school is forced to divide her time between several different hospitals, so the follow-up work is difficult. The student had to make an adjustment first of all from the quiet environment of the school to the busy atmosphere of a hospital where she was unknown and strange, followed by further adjustment to the different hospitals to which she was sent. As every gardener knows, transplanting a seedling always delays growth for a short time. Nevertheless, the reports on these students have been good. They have taken their work seriously and proved reliable. The older ones found the hospital work tiring but would probably do excellent work in a home.

The salary of the qualified nurse aide is approximately 75 per cent that of the graduate nurse. Many graduate nurses do not feel that the nurse aide carries 75 per cent of the nursing load. The graduate admits that the nurse aide is a valuable assistant but feels that her scope is limited. It is true that she has not had much teaching and training. Perhaps the biggest problem is that the graduate nurse is still learning how to assign work, supervise and teach instead of struggling to do so much herself.

The supervision of auxiliary workers and instruction on the job may have to be added to the curriculum of the student nurse since, if the nurse aide is recognized as a permanent member of the hospital staff, she has to be used to advantage by the nurse in charge, who in turn must understand how to assign duties to her. Inconsiderate and tactless handling causes friction, rapid turnover of staff, and insecurity to the worker in question. Poor instruction and supervision lead to mistakes which in turn lead to fault-finding. This is followed by a feeling of insecurity and resentment on the part of the nurse aide. Time must be spent in proper teaching,

repeated demonstrations, and good follow-up on the ward, in order to gain good dividends in nurse aide service. Nurse aides can be encouraged to carry more and more of the nursing load as long as there is adequate supervision and better teaching.

The task of selecting candidates for nurse aide duties is not without its difficulties. The most promising may prove disappointing, the most unlikely valuable. A pleasant personality and good appearance are essential. The girl should be strong and healthy as far as it is possible to judge. She is more likely to stay on staff if free from domestic responsibility. Changing shifts causes difficulty, especially where there are children at home, so that the married woman is somewhat of a risk. One needs a person with a genuine interest in nursing and not a girl merely looking for a job and a pay cheque.

The selection of a suitable uniform for this group is important. It must add to their dignity and prestige and inspire a certain amount of confidence, yet it must be distinct from that worn by students and graduates. There is a tendency for nurse aides sometimes to pretend to be nurses and they can be quite convincing on occasions. We have found the handkerchief cap both becoming and distinctive, while the word "Aide" in large red letters on the white uniform leaves little doubt as to their status.

The teaching program for nurse aides must be taken seriously with nothing haphazard about it. The selection of their instructor is an important matter. She must be enthusiastic for her group, an excellent teacher, kindly yet strict, professional and able, by her example, to portray a good approach in dealing with people.

There are other workers on a hospital ward who must cooperate to give a unity of total care. These are the orderly, the ward clerk, and the ward assistant or maid.

The orderly is a very essential member of the nursing team. Yet, in the average hospital, insufficient attention is given to his preparation or to his efficient contribution to the welfare and comfort of the patients. A good orderly is a tremendous help—a poor one is a positive menace. His position is not altogether satisfactory from anybody's point of view, least of all from his own. He works under the direction of the head nurse but she is not, in all instances, responsible for his work. He has little prospect of advancement or of self-improvement in his job. His daily routine usually holds very little of real interest.

The work of the orderly is comparable with that of the nurse aide. We agree that the nurse aide should have adequate instruction plus good supervision in order to ensure good care of the patient. In the armed forces the sick bay attendants and nursing orderlies were given a certain amount of instruction and responsibility with regard to the nursing. Probably all orderlies would have greater satisfaction in their work if they were more closely identified with the total care of the patient and were used on a male ward in the same way that the nurse aide is used on a female ward. It might be practicable to staff some male wards with trained male attendants, with a graduate nurse in charge. Schools of nursing might well adapt programs for the training of male nurses who, after being duly registered, would be capable of taking charge on such a ward. This arrangement would iron out some of the friction which exists and might be the answer to procuring good orderly service.

The ward clerk is an accepted auxiliary worker in many American hospitals and is gradually appearing in Canada. Present-day ward administration is encumbered with an accumulation of detail. Head nurses spend valuable time copying timetables, requisitioning supplies, writing up reports on charts, answering the telephone, and directing traffic generally. Some of this requires professional knowledge but much of it does not. The head nurse could be relieved of much of this routine work by the ward clerk.

Finding the suitable person for this position is the problem. She must be accurate, reliable, and efficient, yet not officious. She must have initiative but not overstep her limitations. An older person probably is preferable, since she is more likely to stay in her job. It is difficult to instal a ward clerk if the hospital is old and not designed for present-day demands. To be of real value, she should serve a large unit with her desk, separate from the nurses' station, in a prominent position where doctors and visitors pass. She needs her own telephone and equipment.

As in the case of nurse aides, to pay dividends in terms of good performance, time must be spent in initiating the ward clerk into her duties. The whole situation can be most confusing to a person unused to hospital life and, unless well taught, she wastes her own time and that of the nurses as well. She must have a firm grasp of all the detail before she is left on her own; otherwise she becomes discouraged and resigns.

Ward assistants are a group who come between the nursing and the housekeeping departments. They are chiefly concerned with non-nursing duties, yet come in contact with the patients. Twenty years ago the student nurse carried out all the duties of the ward assistant in addition to nursing the patients. She dusted, cleaned equipment, arranged flowers, carried trays, and ran messages. The ward assistant was added when we realized what valuable nursing hours were being wasted. Now we have the nurse aide to carry out semi-skilled nursing duties as well. The combined work of all these workers is necessary for the smooth running of a unit. It might be wiser to combine all nursing duties and all housekeeping duties under their respective departments to prevent overlapping. The nurse aide can supplant the ward assistant and combine many of her duties. Where too many groups are responsible, we do not have efficiency or serenity.

In reviewing the whole picture of the auxiliary worker in the hospital, good care of the patient will result if there is good coordination. Teaching, supervision, and direction are all required to bring to the bedside thoughtful, kindly nursing service.

The Battle Against Leprosy

(*Continued from page 547*)

an excellent reputation and has achieved remarkable results with the new drugs. A number of patients were discharged as cured; others are making rapid progress towards recovery; complications leading to blindness and deformities are becoming less and less frequent. Preventive measures, including medical examination of school children and treatment of the disease in its early stages, have proved extremely effective. Of 100,000 children examined, 220 were found to be suffering from the disease.

Considerable sums of money are provided by the Colonial Development and Welfare Fund of the British Colonial Office to further the anti-leprosy campaign. But it is on the British Empire Leprosy Relief Association (B.E.L.R.A.) in London, a welfare organization maintained by voluntary contributions, that dozens of large and small hospitals and clinics chiefly depend for the training of doctors, nurses, and other workers. Representatives of this organization go overseas in an advisory capacity, giving expert advice on the spot; medical supplies of all kinds are made available; and contact is made with other organizations and with individuals in the British Commonwealth willing to assist in the good work. In cooperation with the British chemical industry, experiments are being regularly carried out with new drugs and this research has recently led to the discovery of a specific drug of unexampled efficacy. It is confidently expected that this new drug, as yet unnamed, will do much to halt the ravages of the disease and that it will, in fact, mark the turning-point in the battle against leprosy.

Nursing Profiles

Madeline S. Taylor is director of provincial organization for Quebec for the Canadian Cancer Society. Graduated from the Montreal General Hospital in 1924, Miss Taylor engaged in private nursing for a year and a half before joining the staff of the Montreal branch of the Victorian Order of Nurses. She was recipient of the Mildred Forbes Scholarship, awarded by the M.G.H. in 1928. After receiving her public health certificate from the McGill School for Graduate Nurses, Miss Taylor went to Saskatchewan where she was instrumental in organizing a new V.O.N. branch in Regina. In 1931 she returned to the Montreal branch where she acted as supervisor—first of Rosemount district and later of the North End district. She resigned in 1940 to enlist with No. 14 Canadian General Hospital, R.C.A.M.C.

After six months at Camp Borden, Miss Taylor went overseas with her unit. In 1943 she left England for service in the Italian Campaign and was on a ship that was torpedoed en route. While in Italy she was acting matron of No. 11 British General Hospital for a time. Returning to England in 1944, Miss Taylor was the first Canadian nurse to be discharged from the R.C.A.M.C. to join UNRRA. She proceeded to Germany as a team nurse. Six months later she was made a supervisor and when the work was reorganized she became the chief nurse with UNRRA in the American Zone of Germany.

Miss Taylor was matron of the displaced persons reception centre at St. Paul l'Ermite, Quebec, for some time after her return from Europe. She was recently elected president of the Montreal Unit of the Nursing Sisters' Association of Canada.

Max Gragge

MADELINE TAYLOR

FLORENCE QUIGLEY

Florence Phyllis Frances Quigley is an associate professor of nursing education at the University of Western Ontario School of Nursing. Born and educated in London, Ont., Miss Quigley entered the school of nursing at Victoria Hospital, London, with her B.A. degree. Since graduating in 1929, she has added two more degrees to her qualifications —B.Sc. in nursing from U.W.O. and M.A. from Columbia University, New York.

Miss Quigley's first position was as instructor at the Public General Hospital in Chatham, Ont. A year later she transferred to her alma mater where she was in the teaching department until 1943. After a year in private nursing, Miss Quigley was appointed director of Home Nursing, First Aid and Emergency Nursing Reserve with the London branch of the Canadian Red Cross Society. She was appointed to her present position in 1949.

Keenly interested in community activities, Miss Quigley is active in many organizations

beside nursing, including the Y.W.C.A. and church groups. For relaxation, she turns to such pursuits as drama, opera, reading, and knitting. She is fond of travel, also.

Berthe Bourbonnais is now the educational director with the Metropolitan Life Insurance Company nursing service in Montreal. Born in Coteau du Lac, Miss Bourbonnais was educated in Montreal and graduated from Hotel-Dieu there in 1923. She joined the M.L.I.C. nursing service in 1926 after three years of private nursing. Her first appointment was with the Sherbrooke branch. She received a company scholarship in 1928 and enrolled in the public health nursing course at the University of Montreal. Her next five years were spent at Rivière du Loup, then back to the Montreal branch until she was appointed head nurse at Quebec in 1937. She returned to Montreal in 1944 and has moved ahead steadily from head nurse to supervisor to her present position. Miss Bourbonnais has enriched her professional preparation through a post-graduate course in nursing education at Simmons College, Boston, and through an observation tour arranged by the M.L.I.C., both on scholarships.

Miss Bourbonnais has taken an active part in association activities. She is secretary of the French chapter of District 11, A.N.P.Q., and a member of the Comité des Ecoles. She enjoys reading and travelling, loves to cook and to make her own clothes. Her latest accomplishment is learning to play canasta.

Ruth Gaw assumed her duties as director of nursing at the Guelph General Hospital in June. She graduated from the Hospital for Sick Children, Toronto, in 1931. After a brief period as assistant head nurse there, Miss Gaw engaged in private nursing for five years.

LaRose, Montreal

BERTHE BOURBONNAIS

She was in charge of the operating room at Anson General Hospital, Iroquois Falls, Ont., for two years prior to her enlistment with the R.C.A.M.C. Upon her return from overseas in 1945, Miss Gaw enrolled in the course in teaching and supervision at the McGill School for Graduate Nurses. She joined the teaching staff of the Homoeopathic Hospital, Montreal, in 1946, becoming assistant to the director of nursing the following year.

Isabel Lowrie has retired as matron of the Municipal Hospital, Claresholm, Alta., after 20 years of active, happy service. Holding the unique record of being the first girl from Claresholm to go into training as a nurse, she graduated from the Calgary General Hospital. Much feted at the time of her retirement, Miss Lowrie had the joy and satisfaction of seeing the new wing of the hospital officially opened before she left. She will continue to reside in Claresholm.

In Memoriam

Louise Flanagan, R.R.C., a Welsh nurse who saw active service during World War I and who engaged in hospital duty in Vancouver some 30 years ago, died there on May 2, 1950, at the age of 82.

Madaline (Duncan) Gordon died in Batavia on March 28, 1950, following a long illness.

* * *

Elizabeth J. Kenny, who had practised

Ashley & Crippen, Toronto
AGNES C. NEILL

her profession in Toronto for some years, died there on May 6, 1950.

* * *

Winnifred E. (Forbes) Monroe, who graduated from Clifton Springs Hospital and who for a number of years was on the staff of Wellesley Hospital, Toronto, died in Ottawa on April 30, 1950, after a short illness, at the age of 64. During World War I Mrs. Monroe served in England and France.

* * *

Nora B. Montgomery, who graduated from the Woodstock General Hospital, Ont., in 1915, died in Woodstock on May 10, 1950, after a long illness. Miss Montgomery was overseas with the C.A.M.C. during World War I and, afterward, was on the staff of the Westminster Hospital, London, Ont., for nine years before ill health caused her retirement.

* * *

Agnes C. Neill, O.B.E., R.R.C., LL.D., a graduate in 1925 of Toronto General Hospital, died suddenly in Peterborough, Ont., on May 5, 1950. From 1926 to 1935 Miss Neill was head nurse in the Private Patients' operating room. A year at Bedford College, London, Eng., preceded her appointment as surgical supervisor at T.G.H. In September, 1939, she resigned to enlist with the R.C.A.M.C. She went overseas as matron of No. 15 C.G.H. in 1940. Two years later she was appointed Matron-in-Chief overseas.

In 1945 she returned to Canada to become Matron-in-Chief of the R.C.A.M.C. Nursing Service in Ottawa with the rank of Lieutenant Colonel. She retired from active service in 1946. For a time she was an area nursing consultant with the Department of Veterans Affairs.

A vital, dependable, sympathetic personality, Miss Neill was a woman of many interests. She had taken an active part in the activities of various professional organizations and was well loved by all who knew her.

* * *

Mary Catherine Stewart, who graduated from the Toronto General Hospital in 1895, died suddenly in Toronto on April 28, 1950. Hospital positions were held in Chicago prior to World War I when she served overseas with the Q.A.I.M.N.S. and the C.A.M.C. She was superintendent of the Guelph General Hospital for many years.

* * *

Evelyn (Dawe) Ure, who graduated from the Vancouver General Hospital in 1924, died in Nelson, B.C., on May 4, 1950, at the age of 47. Mrs. Ure worked at the V.G.H., at Royal Columbian Hospital in New Westminster, and was a supervisor at Kootenay Lake General Hospital, Nelson, for a time.

* * *

Dorothy (Hoover) Wood, who graduated from the Mack Training School, St. Catharines General Hospital, in 1925, died on April 7, 1950.

The Eskimo

There is some confusion as to the exact origin of the word "eskimo" although it is generally conceded to have come from the North American Indians living to the south of the polar regions. It means "people who eat their food raw."

Anthropologists agree that the eskimos are one kind of North American Indian, both in blood and in language.

About 2,000 years ago the eskimos dwelt in the forests north of Lake Superior. For some reason they migrated northward until they reached the arctic coast of Canada. There they split into two main bands—one travelling northeast, the other southeast.

Gradually they spread out until today various eskimo bands are found throughout the north.

Lyle Creelman *Writes . . .*

Average reading time — 5 min. 36 sec.

We have just attended the opening of the Third World Health Assembly. From the gallery of the Assembly Hall in the Palais des Nations, Geneva, we watched the representatives of 61 nations as they took their places. Outstanding among them was Her Excellency Rajkumari Amrit Kaur, Minister of Health for India and leader of their delegation. She was dressed in a beautiful mauve silk sari which the women of India wear so gracefully. Later the Rajkumari was elected President of the Assembly —a singular honor and we were, of course, proud that it was accorded to a woman. Another colorfully dressed delegate was Mrs. Aung San of Burma. In the whole Assembly there are only three women delegates, the third being Mrs. Whitehurst, from the U.S.A., where she is very prominent as an organizer of voluntary work.

Each Member State is permitted three delegates and as many advisers as they wish to bring. Only two countries have sent a nursing adviser —the United Kingdom and the United States. I look forward to the possibility of Canadian nurses being represented by one of their own members at future World Health Assemblies. Mrs. Patterson, who has just received an appointment as Dean of the School of Nursing of the University of Washington in Seattle, came from the United States, and Miss Udell, Chief Nursing Officer for the Colonial Service, from the United Kingdom. The International Council of Nurses is represented automatically as it is one of the non-governmental organizations which has official relationship with WHO.

Mr. Trygve Lie, Secretary-General of the United Nations, addressed the Assembly, and reminded us that the real challenge of the second half of the 20th century "is not expressed in the ideological and power conflicts that monopolize the headlines today. The supreme challenge is presented by that great majority of the population of the world—over 16 hundred million—whose poverty, hunger, and insecurity must be substantially remedied if they are not to result in new and disastrous upheavals. Most of these people live in the so-called under-developed areas of the world, mainly in Asia and Africa. They are moving rapidly toward political equality. They will no longer accept the grinding poverty that has been their fate for centuries. We cannot meet this challenge successfully at the snail's pace of today. We cannot meet it by half-way measures. We cannot postpone it until a more convenient time. The challenge is here and now. Bold and creative action on a world-

Conducting the meeting

wide scale is required in order to bring about real improvements in the living conditions of these 16 hundred million people—improvements that will begin to be evident within the next five years and will have as their goal the doubling of living standards within 20 years in many of the poorer areas of the world." Mr. Lie thus presented a real challenge to us as members of one of the Specialized Agencies whose program is indispensable in attaining this goal.

The Secretary-General then laid the corner-stone of our new permanent Headquarters. As I write now the noise of the machinery is loud and continuous since the building is being erected just across the courtyard from our present offices. In the picture you will see, on the extreme left, Dr. Brock Chisholm, Director General of WHO, in the centre Her Excellency Rajkumari Amrit Kaur, and on her left, Mr. Trygve Lie.

Next week the Program Committee will discuss the report of the Expert Committee on Nursing which met for the first time last February. We think that they will approve the report, after which it will be printed and available for all of you to read. I hope you will study it carefully and remember that the committee had to keep in mind the needs of all the countries of the world, including, for example, such geographically small areas as Liberia. Yesterday Dr. Togba, delegate from that country, told the Assembly something of their problems. They have two and a half million people and only 30 doctors! Outside of their capital city, Monravia, they have no roads. Modern sanitation is non-existent. But here is the hopeful thing for nursing—in their one school they are insisting on high school graduation for entrance so that they can send some of their nurses abroad for post-graduate study. They will return to their own country to be the leaders in nursing. Their main task will be to help develop more schools for the preparation of the nursing personnel needed in such great numbers. Through setting such standards as this, Liberia is taking the wiser and the long-term view, which is so hard in the face of the many immediate needs.

I wanted to tell you about my first trip to Paris over last week-end. Paris is everything you have read about it, and just now—with the chestnut trees in bloom, the fountains playing, and the principal buildings illuminated—the city is a never-to-be-forgotten sight. I had the pleasure of driving around one evening with Dr. and Mrs. Rolf Struthers, formerly of Montreal, now with the Rockefeller Foundation in the European Office. Dr. Struthers had just returned from a two-month trip to Africa where he met many Canadians. We do get around! Luckily for me I had a chance to drive from Paris to Geneva. All along the road through the Forest of Fontainebleau, young and old were selling great bunches of lily of the valley which they had picked in the woods. The countryside was at its best—fruit-trees in blossom and lilacs, white, mauve, and purple, in abundance. We had dinner in Dole—a centre for wine-growing and the home of Pasteur. This country is so full of beauty, history, and interest that I am sure it will never lose its fascination for those of us from a very young nation.

Annual Meeting in Alberta

The 32nd annual meeting of the Alberta Association of Registered Nurses was held in Edmonton April 13, 14 and 15, 1950, with 276 members registered.

Miss J. Clark, president, called the meeting to order at 9:45 a.m. Rev. A. McQueen, Robertson United Church, gave the invocation. His Worship the Mayor, Mr. Parsons, gave the address of welcome to all members. On behalf of the association Miss A. Hoyt, Lethbridge, replied to the address of welcome.

The institute held for the first day and a half studied the "Problems of the Aging Population." The advances of medical science have resulted in helping people to live longer thus creating new problems. Many things are being done to alleviate the ailments so closely linked with all ages. Speakers stressed the difficulties encountered in arranging domiciliary care, the importance of providing homes for the chronically ill, the necessity for adequate diet, exercise and occupation. Caution was advocated in the use of infra-red lamps with the aged.

The value of occupational and vocational therapy was recognized. Warning was given against aged persons undertaking leather-craft work which required good eyesight and coordination. Rug-hooking was suggested as more suitable activity. Employment in types of work where quality service is preferred to speed was advocated.

Lively discussion was a notable feature of the institute. It was the consensus that nurses in their own communities were in a position to crusade for adjustments in the problems of the aged on a non-sentimental basis. A large number of experts discussed various aspects of the problem during the institute.

In her presidential report Miss Clark remarked that the past year was one of growth for the association. The active membership of 2,322 was the highest on record. For the first time the associate membership was made available to non-practising nurses and 891 members joined on this basis. She welcomed delegates from chapters and districts and hoped that during the next year more chapters would be organized. 1949 marked the first year of the increased fee and we were able to return to savings an amount equivalent to that borrowed to cover the operating deficits in 1948 and 1949.

JEAN S. CLARK—*President*

The registrar's report showed that chapter formation had been one of the most outstanding and gratifying projects of the year. The following important changes in policy were noted: Courtesy permits discontinued; change in policy regarding temporary permits; change in by-law regarding associate membership.

The progress of *News Letter* advertising was reported. To date we have had paid advertising in the approximate amount of $900 and have prospects of more for future issues.

The treasurer referred to the auditor's statement for 1949 which indicated that receipts for the year amounted to $20,288.36—of this amount membership fees totalled $18,771.50. Expenditures amounted to $16,872.54, leaving a surplus of $3,415.82. On April 1, 1950, $2,993.48 was invested in Ontario Hydro Electric Power shares.

Miss Shaw and Miss Chapman gave reports on *The Canadian Nurse* and submitted a resolution that the A.A.R.N. incorporate in the annual fee for active members the subscription fee of $2.50 per year for *The Canadian Nurse*. We are happy to state that this resolution was unanimously endorsed.

Miss Helen Peters reported that 20 students had been benefitted by the Dominion-Provincial Grant—6 having received financial aid in the full amount of $150 and 14 received $75 each.

Miss Clark reported that the Health Survey Committee had been meeting monthly during the past year and hoped to present a final report by this fall. She expressed her sincere thanks for the cordial reception received on visits to all parts of the province. She further reported that the committee had met with all the Liaison Committees; the A.A.R.N. Liaison Committee met with the Survey Executive October 4 and with the entire Survey Committee on October 20 and recommendations submitted by the A.A.R.N. were reviewed at that time. Miss Clark reported that 10 Dominion Health Grants were again available to the province for the 1949-50 fiscal year in slightly higher amounts than the preceding year.

For the first time in our association, disability insurance has been under consideration. After studying many group plans, that of the North American Life and Casualty Co. was approved and presented to the general meeting and endorsed by a majority.

Miss M. Cogswell submitted the following resolution:

WHEREAS, In a democracy everyone should be able to plan for security in his old age; and

WHEREAS, There is no pension plan available for the majority of nurses in Alberta; therefore be it

Resolved, That the Alberta Association of Registered Nurses request the Associated Hospitals of Alberta to endorse a pension scheme for nurses employed in Alberta hospitals.

The report of the Legislation Committee proposed the following changes and additions to the A.A.R.N. Act and By-laws:

1. By-Law I (p. 6 of the Alberta Registered Nurses' Act) has been revised: *Associate* (*non-practising*). Add (3) Associate members, failing to renew their membership on or before the first day of February each year, shall become inactive (non-practising) members.

2. Every active member, who has failed to pay the annual fee hereinafter provided by the 15th day of February in that year, shall be suspended as a member of the association.

Form D—Annual first notice of Active and Associate Membership Fees now reads "For active members, it is further provided . . . this association."

Form E—Annual 2nd notice of Active Membership Fees (deleting "and Associate").

Nursing Permits: (a) Annual temporary permits to be issued for not more than two years to applicants for reciprocal registration:

(i) Who do not meet the academic qualifications of the Alberta Registered Nurses' Act at the time at which they become registered elsewhere or (ii) who are now working under Temporary Permits during which time they will be required to make up their academic deficiencies or to write and pass the Grade XI Placement Examinations as administered by the Alberta Department of Education.

That these nurses who hold a Temporary Nursing Permit Statement be granted annual Temporary Permits for not more than two years during which time they must make up their deficiencies and become eligible for registration.

It was with a great deal of pleasure that we had the privilege of hearing from Miss Florence Martyn, a 1915 Royal Alexandra Hospital graduate, who has had a most color-

Council of A.A.R.N.: Seated—MAY DEANE-FREEMAN *of Calgary;* FRANCES MCQUARRIE *of Edmonton;* ELIZABETH BIETSCH *of Edmonton;* HELEN PENHALE, *Director, University of Alberta School of Nursing; Standing*—FRANCES FERGUSON *of Calgary;* SISTER ANNUNCIATA *of Banff;* JEAN BROWN *of Calgary.*

ful nursing career, both in America and India. Miss Martyn has been studying for her degree in public health in Washington, and is now on her way to Pakistan to assist in setting up a Department of Public Health in that country.

The Educational Policy Committee proposed the following resolutions which were endorsed by the general meeting:

(1) That the committee go on record as approving the principle of Evaluation and Accreditation as sponsored by the C.N.A.

(2) That the committee go on record as disapproving the organization of a Student Nurses' Association in Alberta at this time.

(3) That each school of nursing be circularized in regard to sending at least one student delegate to the C.N.A. biennial in Vancouver.

(4) The committee did not approve of providing official transcripts of nursing courses as it was felt that these might not be correctly interpreted by other registered nurses' associations.

At the Institutional Section meeting, the suggested personnel policy outline of the C.N.A. was read and discussed. The following resolutions were proposed and endorsed:

WHEREAS, In various hospitals employing nursing aides there appears to be an insufficient differential in salaries paid various grades of nursing personnel; and

WHEREAS, There is considerable variation in salaries paid to registered nurses in the different hospitals of Alberta; therefore be it

Resolved, That a committee be formed to study and formulate a provincial salary schedule for nurses.

This committee has now been appointed.

At the Public Health Section meeting, it was the consensus that financial recognition was not made for post-graduate and degree work in the Provincial Department of Health and it was proposed that this be brought to the attention of the department.

At the meeting for official delegates of districts and chapters reports were heard from six districts: Ponoka, Calgary, Medicine Hat, Red Deer, Edmonton, and Lethbridge. Reports were also received from the six chapters newly formed at Banff, Jasper Place, Peace River, Vegreville, Blairmore, and Grande Prairie. Discussion developed as to whether the financing of the chapters should be a district or provincial responsibility.

Miss Ferguson, Registration Consultant of Nursing Aides, reported many noteworthy

developments in nursing aide fields. The 40-week training program has been subdivided to provide for a 15-week period of instruction at the school, two periods of 10 weeks each at hospital training fields for nursing experience under supervision, with a period of 5 weeks for review and final examinations. Effective April, 1950, there are 344 certified nursing aides and 147 trainees.

At the Nursing Aides Advisory Council meeting in October, 1949, salary and uniform revisions were approved as follows: The recommended minimum salary schedule for aides in hospitals is now: 1st six months, $100 gross; 2nd six months, $110; 2nd year, $115; 3rd year, $120 per month gross. The recommended minimum schedule for aides engaged in private duty is $4.50 per eight-hour day plus 50 cents an hour for overtime, and meals while on duty; for full-time home duty (a normal working day) $100 per month.

At the Private Duty Section meeting, the financing of registries was discussed. At the present time the financial standing in all the districts is most encouraging. Some concern was expressed by the private duty nurses regarding the nursing aides wearing caps and pins. The A.A.R.N. has presented a recommendation to the Nursing Aide Council that their caps be a distinctive grey. It was pointed out that in some hospitals and doctors' offices nursing aides and non-certified auxiliary workers were being asked to assume responsibility for the things for which they are not prepared. It was proposed that a recommendation be sent to the College of Physicians and Surgeons and the A.H.A. protesting this matter.

CLARA VAN DUSEN
Registrar

I had a Dream

It seemed to me I stood
In a small garden, hedged and brimming over
With exquisite flowers—honeysuckle, clover,
Roses and harebells—lilies white and tall;
Flowers of spring and summer mixed and on them all
The shade of guardian trees and radiant light;
Till, half aloud, I said, "This heavenly place!
Whose can it be?" Then, as I stooped to see
A half-hid flower, lo! I caught a sight
Amazing; little graves were crowded there,
So small I had not seen them—yet there were
Nothing of loss or sadness—just delight!

A little breeze stirred round me and I heard
An answering whisper—"This is all your own.
Here you have buried, like a deep-dropt seed,
Thoughts and desires you were ashamed to own,
Sifted them as they rose to birth again;
The scornful word, the ungenerous deed,
The look, the laugh, that had a hint of pain.
So are the spirit forms of these most fair.
The Alchemy of Love changed them to flowers
To enrich your life and cheer your loneliest hours."
I woke as I had slept, with wondering joy!
And now, whatever life to me may seem,
Love gives to me the comfort of my dream.

GRACE H. BAKER
Age: 83 years

Trends in Nursing

Average reading time — 10 min. 24 sec.

Canada Leads

"CANADA," to quote an article by Mr. H. L. Keenleyside in the *International Journal*, "is now, in relation to its population, one of the two or three most richly endowed countries of the world." Is that not something to make us pause and consider the Canadian people's responsibility for the common material problems facing humanity? The recognition of this necessity emphasizes also the need for an increased population in this country. The present population of Canada is inadequate for the most effective development of our natural inheritance.

> Moreover, as the pressure of population on the means of subsistence elsewhere grows more onerous, there will be an increasing demand that Canada provide homes for many of those who are elsewhere dispossessed. In admitting immigrants from other parts of the world we are lessening the political dangers to which we are exposed by the magnitude of our riches; and at the same time we are building up within Canada a greater power of production that can be used to the advantage of ourselves and of humanity as a whole.
>
> So long as any human beings, anywhere, need shelters; so long as anyone, anywhere, lacks fuel or clothing or food, so long will the demand for Canadian products and services persist. Our forests, our fields, our lakes and seas provide a vast store of renewable resources, and by proper husbandry they may be made a permanent reservoir on which we may draw to satisfy the elementary material needs of the men, women, and children of every land.
>
> As the trustees of a great inheritance we have a responsibility as well as an opportunity. The responsibility is to the people of the world who urgently need the resources with which we have been so generously endowed. The opportunity is to meet this need and, in doing so, to profit ourselves and our country. Thus we have been doubly favored and our obligation is proportionately increased. It was Christ Himself who said that "unto whomsoever much is given, of him shall be much required."

Economics—A Way of Life

In a forceful address, Dr. M. M. Coady, Director of Extension for St. Francis Xavier University, has declared that the most important consideration in any plan for solving present-day economic and social problems is the evolving of a scientific and democratic method through which to distribute created wealth.

Through centuries the people have struggled to free themselves from slavery and the ideal for which they fought was individual ownership and private initiative. This had eventually been obtained but, unfortunately, certain individuals and organized groups obtained control of wealth and resources which, though inherently belonging to the people as a whole, were used to institute and perpetuate a new type of economic slavery.

> There is a movement in progress which is the real revolution—the process by which the people can enter business and, through their cooperative efforts, participate in the wealth which they create. It is the only solution which will save democracy, if the awful forces of bloody revolution now rampant will not engulf us before such orderly processes can become effective enough to stave off the cataclysm.—excerpt from *The Maritime Co-operator*

Whose, the Responsibility?

A spot study made in January, 1947, of 26 leading hospitals in Canada revealed that student nurses were carrying from 33 to 85 per cent of the service load to the detriment of their educational experience.

Surely this is factual evidence that

there is something wrong, not only with the method of educating students for nursing, but also with the method of providing nursing service in hospitals.

Educational programs to meet ever-increasing nursing service requirements demand an ever-increasing number of hours of lectures and demonstrations. Present hospital school practices include one or other of the following methods of procedure:

(a) *Class hours interspaced throughout nursing service periods*—a procedure frustrating to the student and unsatisfactory to the patient whose needs must be transferred to another nurse, with oftentimes an intervening period of non-attention; or (b) *a block system* which in many instances causes mental indigestion from the cramming process where correlation of practice and theory are impossible of achievement.

Thirty years ago, the age requirement of students was approximately 23, whereas now it is generally 18. Fundamentally, nursing has to deal with human beings during periods of fear, stress, and pain. It requires a deep understanding of human nature and behavior. The immaturity of the average student today, which is not a mere matter of chronological age, provides a situation where many personal as well as professional adjustments have to be made. We take many young girls who have been academically and socially prominent in high school and thrust them into a situation with fewer social and cultural contacts. We must provide adequate mental hygiene and counselling facilities to help these students make adjustments to the complexities of hospital life, as well as to enable them to live a full life after graduation.—excerpt from *Nursing—a Social Institution*

Health Examination and the Worker

The statisticians of the Metropolitan Life Insurance Company report that 250,000 diabetics are employed in the United States and that the number is growing from year to year. Most diabetic workers are over the age of 40 and their absenteeism rate is little higher than that of non-diabetics and not much of the time lost is due to their disease.

The employer and the industrial physician can do much by encouraging the employee to obtain good medical supervision, to learn the facts about the disease, how to avoid diabetic coma or insulin reaction and what to do if either impends. The employer can also aid in the early discovery of diabetics by providing for routine laboratory tests for the disease at the annual medical examination of workers or by intensive case-finding campaigns in his plants.—excerpt from *Metropolitan Information Service*

An Allied Field Experiment

A five-year experiment in medical education which may revolutionize the teaching of medicine has been undertaken by the School of Medicine at Western Reserve University. The objective is to turn out physicians who are better equipped to apply scientific knowledge for the health of humanity. The plan, which is original with the medical school, involves scrapping the present curriculum gradually and substituting a new one in which the material taught will be woven together so that from the beginning the medical student sees and feels that man as a whole being is his concern.

Deficiencies in the present educational program in medical schools include the following, according to Dr. Wearn:

(1) Students are forced to learn a tremendous number of unrelated details. (2) The laborious coverage of factual material deadens initiative and curiosity. (3) Each individual department presents its subject matter without close relation to the offerings of other departments. (4) The separation of preclinical training from clinical training in the second two years tends to emphasize the differences rather than the interrelation of basic sciences and patient care. (5) Many teachers have attained their positions on the basis of research or care of patients and are not necessarily interested or prepared for important educational

responsibilities. (6) The medical curriculum has grown by addition of new material, has not been drastically pruned or rearranged for 30 years, and has not been reoriented extensively in spite of the great changes which have occurred in medical practice and distribution of medical services.

The project represents a serious attempt to remedy such deficiencies by improving the order, relationship, and quality of the material presented to medical students. Dr. Wearn said: "It is an attempt also to restore the proper emphasis on teaching." Commenting on the program, Dr. Millis said:

> I believe that this is the most important experiment in medical education that has been undertaken in 30 years. The effect of this experiment will be felt, not only in medical education throughout the country, but also in general education where re-evaluation and change is greatly needed.—excerpt from *Public Health Economics* (March, 1950)

Sounds Familiar

We have been asked by Council to approve raising the annual subscription; such a change could not come into effect until 1951. With the overall rise of the cost of running a professional organization it is impossible to continue the present work of the College on an annual subscription of one pound. If the members at the annual general meeting vote against an increase, a drastic cut in all branches of the work and a reduction of professional and clerical staff will be required, resulting in the curtailment of expert advice and information to members personally and to the profession as a whole through such admirable activities as the Nations' Nurses' Conferences and Refresher Courses. We are not alone in facing this financial position. Most similar organizations have already increased their subscription and I cannot imagine that any of us would wish to see Council constrained to retard the work of the College because of lack of money.—excerpt from letter to Branch Members, South Western Metropolitan Branch, *Royal College of Nursing*

Publication

"Group Discussion Methods," published by the University of Manitoba, Adult Education Office, may be purchased for ten cents. For those planning their fall educational programs, this little book would be of great value.

Orientation et Tendances en Nursing

LE CANADA EN AVANT

"Le Canada," d'après un article de M.-H. L. Keenleyside paru dans le *International Journal*, "est en proportion de sa population l'un des deux ou trois pays le mieux partagé du monde."

N'est-ce pas là une déclaration qui doit nous faire réfléchir le peuple canadien sur ses responsabilités en face des besoins matériels des autres pays?

Ne faut-il pas aussi reconnaître qu'un moyen d'aider les pays moins fortunés serait d'inviter un certain nombre à immigrer dans notre pays et nous aider à développer les ressources dont la nature nous a si généreusement dotés?

L'on nous envie à cause de nos richesses. En partageant nos biens avec ceux des autres pays qui sont dans la necessité, n'éloignerions-nous pas certains dangers politiques et du même coup nous augmenterions notre pouvoir de production et ce sera à l'avantage des canadiens comme à celle de l'humanité toute entière.

Nos ressources, administrées avec une saine economie, peuvent constituer une réserve où viendront puiser ceux qui ont besoin d'abri, de nourriture, et de combustible — nos forêts, nos lacs, nos prairies offrent toutes ces ressources.

Nous sommes les gardiens de ces biens. Nous avons l'obligation de faire fructifier

ces biens et la responsabilité de les partager avec les déshérités. Le Christ n'a-t-il pas dit: A celui qui a beaucoup reçu, beaucoup sera demandé.

En Economie — Une Nouvelle Manière de Vivre

Nous avons réussi, durant les siècles passés, à nous débarasser de l'esclavage et l'idéal de toutes ces luttes était la liberté d'action et la propriété privée. Malheureusement, le contrôle exercer par certains individus sur de grandes richesses a créé un nouveau genre d'esclavage économique.

"Le seul moyen de sauver la démocratie des forces revolutionnaires qui menacent de la faire périr est d'appuyer le mouvement de coopérative," dit le Dr. M. M. Coady de l'Université St-Francis Xavier. Par ce moyen tous ceux qui ont travaillé à édifier une fortune ont droit d'y participer.— Extrait de *The Maritime Co-operator*

A Qui Appartient Cette Responsabilité?

Une étude faite en janvier, 1947, dans 26 hôpitaux du Canada, révèle que le soin des malades est confié aux étudiantes dans une proportion variant de 33 à 85 pour cent et ce au détriment de leur expérience educationnelle.

Voilà une preuve évidente qu'il y a quelque chose qui ne va pas, non seulement dans la méthode de former les étudiantes infirmières mais aussi dans la façon dont les hôpitaux assurent les soins à leurs malades.

Les études des élèves, afin de répondre aux exigences de la médecine moderne, doivent être plus poussées, les heures de conférences et les démonstrations plus nombreuses.

Actuellement, deux méthodes d'éducation sont émployées: (a) *Les heures de classes sont placées entre les heures de travail*, ce qui donne aucune satisfaction à l'étudiante ou au malades. Ce dernier se voit confier à une autre infirmière remplaçante dont l'intérêt, envers ce malade qu'elle ne connaît pas, est diminué. (b) *Le système alternatif* ou "block système," lequel peut être la cause d'indigestion mental et avec lequel la corrélation entre la théorie et la pratique est à peine impossible.

Il y a 30 ans, l'âge d'admission aux écoles d'infirmière était de 23 ans — aujourd'hui les élèves sont admises à 18 ans.

Il faut bien comprendre la nature humaine et son comportement pour être infirmière. L'on voit les personnes lorsque la crainte, l'anxiété, et la douleur les assaillent.

Les jeunes filles sortant de ses pensionnats et de nos écoles ont-elles la maturité voulu pour faire face aux problèmes qui se poseront, pour s'adapter à ce nouveau milieu bien différent de celui de l'école?

Il faut donner à ces étudiantes de l'hygiène mentale de l'orientation, afin d'aider ces étudiantes à trouver les moyens de s'adapter au milieu complexe de l'hôpital, et les préparer à vivre une vie remplie après leur graduation.— Extrait de *Nursing—a Social Institution*

Une Révolution Chez les Etudiants en Médecine

L'on va tenter durant cinq ans une expérience qui peut révolutionner les méthodes d'enseignements en médecine. Cette expérience sera faite par l'Ecole de Médecine de la Western Reserve University. Le but est de former des étudiants mieux préparés à appliquer à la santé leur connaissances scientifiques. Le programme d'étude sera changé et un autre lui sera substitué pour l'étudiant en médecine dès le début de son cours, de réaliser ce que l'homme ressent dans son psychique aussi bien que dans son physique et son moral. — Extrait de *Public Health Economics* (mars, 1950)

L'Examen Médical et Travail

Les statisticiens de la Metropolitan Life Insurance Co. rapportent que 250,000 diabétiques aux Etats-Unis exercent un emploi malgré leur maladie et le nombre de diabétiques augmente d'année en année. La plupart de ces employés ont plus de 40 ans et ils ne manquent pas beaucoup plus au travail que les autres employés et la diabète n'est pas la cause de leur absence.

L'employeur et l'industriel peuvent grandement encourager l'employé à se faire suivre par le médecin à se renseigner sur cette maladie — comment éviter le coma diabétique, la réaction de l'insuline, ce qu'il faut faire dans ces cas.

L'employeur peut aider le diagnostic précoce des cas de diabète en ajoutant à l'examen périodique de ces employés des tests de routine.— Extrait de *Metropolitan Information Service*

Publication

"Group Discussion Methods," un pamphlet de grande valeur que l'on peut se procurer pour dix sous en s'adressant à *University of Manitoba (Adult Education Office)*.

Student Nurses

Nutritional Anemia

SISTER CLARE MARIE

Average reading time — 16 min. 48 sec.

MRS. FORD, 35 years of age, was admitted to hospital by ambulance on December 16. She complained of extreme fatigue, shortness of breath on exertion, and a progressive loss of weight over a period of five months previous to admission.

Mrs. Ford was married for seven years before her first child was born. During the first years of her married life she continued to work, although her husband was steadily employed.

Small of stature, Mrs. Ford has a pleasing personality and friendly disposition. She readily adapted herself to hospital environment and was a cooperative patient during her stay in hospital. Her only previous hospitalization was for her two confinements.

MEDICAL HISTORY

Mrs. Ford had an uneventful first pregnancy in 1946, terminating in a fairly normal delivery. After Donald's birth she developed a macrocytic anemia which readily responded to treatment. (This type of anemia is frequently associated with pregnancy.) In June, 1948, she gave birth to a second son. Once again she developed anemia. As she did not gain strength or return to her usual vigor, she reported her condition to the doctor. He gave her a series of 12 liver injections over a period of two months. These injections were stated to have raised her hemoglobin to 75%.

Sister Clare Marie is a student at the School of Nursing, St. Martha's Hospital, Antigonish, N.S.

After the injections, Mrs. Ford's doctor lost contact with her from August to December. During this time she found it most difficult to carry on her regular household duties. Gradually she became overcome with exhaustion. Her legs ached so that she could no longer walk around without feeling as though they would collapse under her. Her appetite became poorer and she had shortness of breath on the slightest exertion. It became necessary for her to stay in bed for periods of three and four days at a time. The minimum of strength thus gained would allow her to get up and around for a day or two. Then exhaustion would overtake her again.

MEDICAL CARE

Mrs. Ford's condition was classified as critical at the time of her admission. It was diagnosed as severe anemia of a doubtful character, probably nutritional. Due to the far-reaching effects of this devastating condition on practically every system of the body, the immediate plan for medical care was complicated. Pertinent information had first to be secured through a series of examinations, tests, and x-rays before detailed care could be planned.

The first investigation was to have a complete blood picture analysis done. On December 17, the accompanying revealing report was filed.

Thus, there was a deficiency of over four million red blood cells, two and a half thousand white blood cells, and 60% hemoglobin.

Another analysis done three days

	Mrs. Ford's	*Normal*
Red blood cells	430,000 per cc. of blood	4,500,000 per cc. of blood
White blood cells	2,500 per cc. of blood	5,000-9,000 per cc. of blood
Hemoglobin	21%	80-90%

later showed a still greater abnormality, particularly in the hemoglobin percentage: Red blood cells—640,000; white blood cells—2,350; hemoglobin —15%.

Such an anemia could be of the pernicious type of which one symptom is the absence of hydrochloric acid in the stomach; it could be due to liver impairment; to an inability on the part of the intestinal tract to absorb the end-products of digestion; or it could be an aplastic type, that is, due to bone marrow deficiency. To arrive at a conclusion as to which was the responsible factor, the following tests and examinations were done:

Gastric analysis test; examination of feces for ova and parasites (which might be interfering with absorption); examination of the gastrointestinal tract for ulcerative areas, tumors, or cancer; liver function tests and bone marrow examination.

The gastric analysis test is made for the purpose of analyzing the contents of the stomach, thereby determining the amount of acid present. Mrs. Ford's test showed the presence of acid; hence, a diagnosis of pernicious anemia was ruled out. An examination of the feces was made for ova and parasites. There were none.

Next, a series of x-rays was taken of the gastrointestinal tract. The substance the patient is given to drink is opaque to x-ray and, therefore, allows the contour of the stomach and intestines to be depicted on the developed film. Any abnormalities can be detected. The report on Mrs. Ford's series showed her organs to be in normal condition. From all these negative results it was logically concluded that anemia was not due to an inability of the gastrointestinal tract to either receive or absorb food. It remained to be seen whether the underlying cause of the condition was to be found in the liver or in the bone marrow.

The liver plays an important role in the life of the red blood cell. It is produced in bone marrow and evolves into a mature cell through a series of migrations, passing from the infant megaloblast to an erythroblast to a normoblast to a reticulocyte to a mature red blood cell. In order to "grow up" the cell needs an essential substance called the maturation factor (anti-anemic principle). This principle is made up of two factors—the extrinsic, which is extracted from the food eaten, and the intrinsic, which is obtained from the gastric juice. The combined essence is stored in the liver. Therefore, a diseased or non-functioning liver would interfere with red cell maturation and this would eventually lead to anemia.

The Icterus Index, the Urine Urobilinogen, and the van den Bergh were the tests done to ascertain liver inefficiency, if any.

The Icterus Index measures the ability of the liver to excrete bilirubin, a pigmented substance derived from the hemoglobin liberated by over-age red blood cells which are constantly being destroyed in the body. Bilirubin is excreted in the bile and leaves the body as part of the feces. The Icterus Index is elevated if the liver fails to excrete bile at a normal rate, whether because of mechanical obstruction to the flow of bile into the intestines or due to damage in the liver cells themselves. With sufficient elevation of the bilirubin content in the bloodstream the patient becomes jaundiced. Mrs. Ford's index was 12.6 units. The normal is *4-6 units*. (With an elevation over 16 units the patient becomes jaundiced. Mrs. Ford was slightly jaundiced at this level).

The following is the mechanism of the Urine Urobilinogen test: Urobilinogen is formed by the action of intestinal bacteria on the bilirubin in the bile. A portion of the urobilinogen is reabsorbed through the intestinal wall into the bloodstream and appears in the urine. This is the basis for the test. Normally there is a certain amount present. If it is absent it may be concluded that there is no bilirubin and, hence, no bile reaching the intestines, either because of biliary tract obstruction or failure of the liver to secrete bile. If liver cells are not functioning adequately calcium bilirubinate and bilirubinoglobin are retained in the blood, the concentration becoming abnormally high. An increased urobilinogen in the urine is one of the earliest signs of liver cell damage. This test showed Mrs. Ford's urobilinogen concentration to be

1-100 units; a repeated test a week later indicated 1-20 units. The latter figures are within the normal range. It can be concluded that the patient had liver damage of a temporary nature.

The van den Bergh test checks the quantity of bile in the bloodstream. From a vein, 5 cc. of blood are withdrawn, allowed to clot, and the serum separated. It is mixed with a reagent which will turn the serum bluish-violet in color. Two types of reaction result—the direct and indirect. In the former there is an immediate reaction, a turning of the color of the serum in 10-30 seconds; in the indirect reaction the results are obtained in 1-5 minutes. The direct reaction is indicative of obstructive jaundice; the other of non-obstructive jaundice. Mrs. Ford's tests were: Direct, 55 seconds; indirect, 1-2 minutes. Thus, the results of the indirect test indicated some liver damage but not of much consequence. Evidently then, this small liver damage could not be the primary cause of such a severe anemia. On the other hand, it is very likely that the liver impairment was resulting from the anemia.

Approximately two weeks after admission, another factor in the condition of this patient called for investigation. It was noted that she was passing a very malodorous urine. A series of x-rays, examinations, and tests was done to determine the cause. A microscopic examination of a cultured specimen of urine revealed the presence of *E. coli*. This is a bacterium, the growth of which produces toxins and pus and these in turn are responsible for putrefaction. This process emits an odor.

A cystoscopic examination and a retrograde pyelogram were done to determine whether or not any pathological condition existed in the urinary organs. A retrograde pyelogram is a procedure which allows for the following: A dye is injected into each ureter by means of special catheters; the dye flows into each kidney and an x-ray is then taken. The result is a clear picture of the kidneys and ureters; if any abnormalities are present they can be easily seen. Such examinations revealed Mrs. Ford's organs to be normal excepting for the presence of a small cystocele (a sac-like protrusion on the anterior vaginal wall caused by a sagging bladder). It was thought that bacteria from the vicinity of the urethral opening were collecting in this cystocele, breeding and causing putrefaction.

A biopsy of bone marrow was performed in an effort to determine the exact diagnosis. It is here that blood cells develop from their immature to their mature stage. It was found that there were 80% immature and only 20% mature cells. Normally about 70-80% should be in the mature state. This would give the impression that the body was lacking some essential factor that was keeping the cells from growing up. The tentative diagnosis following the bone marrow biopsy was leukemia, probably of the aleukemic type.

Mrs. Ford's temperature remained persistently elevated for a period of days, reaching a peak of 103°. Sulfa and penicillin therapy were of no avail in reducing it. Streptomycin was then administered. The temperature dropped but remained elevated to 99.4. It was not established whether the fall in temperature resulted from streptomycin or to an improvement in general body tone.

While these investigations were being carried out, the patient's immediate needs were filled. She was given liver extract—30 units b.i.d.; her diet was planned to combat her nutritional disorders. Her medications were tonic in nature, rich in vitamins. Hemograms were done regularly in order that knowledge thus gained would serve as a working basis for the introduction of newer methods of handling the case.

Mrs. Ford grew progesssively worse and signs of congestive heart failure began to develop. Such a condition occurs because, due to the severe anemia, the heart muscle receives an insufficient supply of blood. Not being able to pump blood adequately, congestion results in the chest cavity. This emergency state of affairs was treated by the administration of oxygen and a blood transfusion. (The latter had been withheld as by transfusing the patient her blood investigation would be interfered with.) These therapies proved to be life-sav-

ing for in a few days Mrs. Ford's condition was improved.

Injections of folic acid were begun on January 17. (This is a purified synthetic preparation of the maturation factor.) It was given intramuscularly, 40 mg. daily. The usual dose is 10 mg. daily. The next day the dosage was increased to 45 mg. A blood examination on January 24 showed a 13% increase in hemoglobin, a red cell count of 1,920,000 and a white count of 7,000.

The diagnosis of leukemia had not been completely outruled as yet. It is generally believed that folic acid therapy is valueless where a condition of leukemia exists. As there was a pronounced improvement in Mrs. Ford's hemoglobin following its administration, it was decided to examine the bone marrow again. The picture at the second examination was the exact opposite of the first. This time 80% of the cells were in the mature state; 20% immature. On January 31 the hemoglobin reached 47%. A week later it reached 57%.

These latter findings confirmed the diagnosis of nutritional anemia complicated by pregnancy.

Nursing Care

In caring for Mrs. Ford every skill and technique of nursing had to be practised. After admission her appetite became very poor. As the underlying cause of her condition was lack of nutrition it was most essential that every effort be taken to encourage her to eat. Food was attractively prepared and tissue-building foods, as well as those rich in vitamins, were given in plentiful quantities. Supplementary feedings in the form of milk shakes and orange juice were given between meals.

Due to poor circulation, Mrs. Ford's skin was in danger of pressure sores developing. Her anemic condition caused her to be very inert; thus, for the greater part of the time, she would lie motionless. This was another factor that would have quickly led to a break-down of the skin if nursing care had been indifferent. It was necessary to change her position frequently and to massage those parts of the body that were sustaining most of the pressure.

When congestive heart failure occurred the blood from the pulmonary circulation was dammed back to the lungs, resulting in congestion in that area with resultant difficulty in breathing. The accumulation of fluid in the lungs and bronchioles caused severe spasms of coughing. Nursing care called for the administration of oxygen, elevation of the head of the bed to facilitate breathing, and giving an expectorant to aid in the spasms of coughing.

As this patient had a persistent fever, her mouth and lips became very dry; the latter also became excoriated and bled easily. This condition was further complicated by the coughing. Regular and special mouth hygiene had to be given. Liquid paraffin was applied to the lips very frequently as, bleeding and cracked, they were a painful source of discomfort to the patient.

As Mrs. Ford was extremely ill during the first part of her hospitalization, it was necessary to take care of her personal hygiene for her. The necessity for this care was further emphasized by the malodorous urine. It was also important to watch out for orthopedic deformities which could result from the patient maintaining the same position in bed over a long period of time.

Mrs. Ford improved steadily during the latter part of her hospitalization. She was given a diet high in calories and gained weight as a result. Her one ambition was to make a complete recovery so that she could return to her home. Towards this end she cooperated splendidly.

Points Taught

Mrs. Ford was cautioned to watch her general health after she returned to her household duties and to notify her doctor without delay if she felt she was not up to normal.

She was instructed to pay special attention to her diet, taking her meals regularly and selecting those foods which are good body builders.

Synthetic Curare

A. W. Haslett

The South American arrow poison, curare, has been a source of interest and challenge to research since it was first described by the Italian, Peter Martyr, in 1516—only 24 years after the discovery of the American continent by Christopher Columbus. Made in remote jungle sites from numbers of different plants and with ritual procedures known only to a few members of the tribes who used it, it is not surprising that the mixture of substances which curare contains has set the chemist many difficult problems.

One of these substances, d-tubocurarine, was first isolated by Dr. King of the National Institute for Medical Research, London, in 1935. He was able to ascertain its chemical structure and to point to a particular group of plants, out of many known to be used, as likely sources. An American, R. C. Gill, then spent several years in the jungle and for the first time brought back considerable supplies both of curare and the plants from which it was made.

The stem of one of these plants is now used as a commercial source of d-tubocurarine, and with supplies assured it has come quickly into medical use. It has proved of value for two purposes. One is to relax the muscles in abdominal operations which before could be done, ordinarily, only under the deepest anesthesia. The other is to reduce the violence of muscular contractions in electric shock treatment.

Well before these developments, chemists for their part had been looking for laboratory-made substances which would have similar effects. They were helped greatly by knowledge obtained by Dr. King of the structure of d-tubocurarine and the first medical trials have been reported of a new drug, known for short as C-10 (and officially as decamethoriun iodide) which can be readily manufactured and is thought to be even more useful than d-tubocurarine.

Poisoned darts, shot from a blowpipe. which could kill at 100 feet made a good beginning to travellers' tales. Sir Walter Raleigh with fine imagination wrote that "the partie shot indureth the most insufferable torment in the world . . . sometimes dying starke mad, sometimes their bowels breaking out of their bellies." Suggested ingredients included everything from underground plants to ants and scorpions. Into this confusion the German naturalist, Baron von Humboldt, brought the beginnings of sense about 1800 when he correctly identified some of the plants used in its preparation. Then about half a century later the French physiologist, Claude Bernard, worked out the chief mechanism by which the poison acts. He showed that muscles were normally stimulated to contract by nerves and the effect of curare was to prevent the muscle from responding to this nerve stimulus—although both nerve and muscle separately retained their activity. Finally, and arising out of his work, French doctors made use of curare in some of the more serious diseases of the nervous system. The scarcity of supplies and the uncertain action of the drug led to the temporary abandonment of its medical use.

Modern medical interest was roused by the hope that some laboratory-made substitute might be found that would be free from the various unwanted effects produced by d-tubocurarine. The ideal muscle relaxant would be one which would block the action of nerves on muscle but for the rest leave the central nervous system untouched. It would also, unlike d-tubocurarine, leave blood pressure unaffected. C-10 is five times as active as d-tubocurarine, weight for weight, in the relaxation of muscles but has less effect on those parts of the nervous system which keep blood pressure up to its normal level. On the other hand, its effect is shorter lived, lasting only from 10 to 30 minutes. This may be of advantage in surgery as giving better control. There is also a synthetic antidote which could be used if necessary. Like any other new and powerful drug, C-10 must be regarded for the present as under trial. On first tests it appears that it should be both an improvement on d-tubocurarine, more generally available, and free from the need for standardization.

Nightgowns were the main cause of deaths from fire of 256 children in a year, 156 of them aged one to five. It is recommended that young children should wear pyjamas tied closely to the body instead of flowing nightgowns.

Nursing Students' Award

This year the second annual competition for student nurses in the field of tuberculosis was held in British Columbia. The competition is open to students of recognized schools of nursing in the province, an award going to the winning students. The award is $50 in each case and the winners in 1949 were Marguerite MacRae and Sister Anne Antoinette, both of St. Paul's Hospital, Vancouver.

Head Nurses' Institute

Eighty-five head nurses from Montreal, Sherbrooke, and Quebec recently spent three interest-packed days together discussing "What is the Job of the Head Nurse?" under the inspiring leadership of Miss G. B. Carter, B.Sc. (Econ. London) S.R.N., presently on the faculty of the School of Nursing, University of Toronto. The conference was initiated and arranged by the Committee on Institutional Nursing of the Association of Nurses of the Province of Quebec, whose able chairman is Miss Norena Mackenzie.

When the committee surveyed the interests of the institutional nurses there seemed to be great need on the part of directors, supervisors, and head nurses for an answer to the stated question. It occurred to the committee that the most logical people to discuss it might be the head nurses themselves. The reality of this assumption was vividly demonstrated by the enthusiastic attendance which exceeded the original expectation many times over.

In order to achieve the objectives of this conference, which was the free expression and exchange of ideas, careful planning was necessary. Every applicant received a mimeographed outline of the discussion as proposed by Miss Carter. Carefully selected references were included. At each session the entire group met for about an hour to hear Miss Carter present the topic for discussion. Following this, small groups were formed for individual discussion under the guidance of previously appointed leaders. At this time there was opportunity to pursue a special line of interest. After half an hour in small conferences the whole group reassembled when the leaders or any members of the conference presented their contributions to the general thinking. It soon became apparent how many common lines of interest there were. Miss Carter then drew the strings of thought together with a new perspective, thereby suggesting many methods of approach.

At the first session the head nurses were asked to consider the fact that nursing might not rightly be called a profession and why. This led to the consideration of the meaning of professional nurse, the rights and obligations attaching to a profession, and the duty of the professional nurse to assume the responsibility for total nursing care required by the community. Then we examined the role of the hospital in the community's health service and the place of the head nurse in the team, with her functions of practitioner of nursing skills, teacher, and administrator.

From the point of view of the head nurse, her responsibility as an administrator was agreed upon. She must be aware of her patients and manage the unit with their best possible care as her main objective. When she assumes authority she must also assume the responsibility which accompanies that authority. She must recognize her place as the member of a team, with an awareness of her capabilities and limitations. It was also generally agreed that, before the head nurse can direct the work of others, she must herself be a skilled practitioner, with a sound background of knowledge based on a solid foundation of general nursing and science. Then, not only must she herself possess this knowledge and skill but she must have an understanding of the special problems involved in passing on her knowledge to others. Techniques of teaching in schools of nursing were discussed in the light of the present knowledge of general characteristics of learning such as motivation, measurement of progress, consequent satisfaction.

The last day was spent on the discussion of evaluation—evaluation of the work of the head nurse herself and of the work of staff and student nurses. This led to the problem of the establishment of criteria of evaluation in nursing. The question then became "What

research needs to be done in nursing, and who will do it?"

By the third day much reticence had been overcome and a great deal of enthusiasm gathered. The climax of the conference seemed to be reached when, in the final open meeting of the entire group, concerted opinion was expressed. Clearly these head nurses felt that the opportunity to take their problems out of context and view them together was something of inestimable value to them. The possibility of becoming an organized group, both within the hospitals and the nurses' association, strongly recommended itself to them and steps were taken to promote such a plan. It was felt that in an organization common interests could be formulated and the needs of the head nurses for professional growth could be met.

To promote a conference such as this, the value of an appropriate place must not be underestimated. Excellent accommodation for the meeting was provided through the hospitality of the school of nursing of the Montreal General Hospital. One of the ample classrooms was thrown open and proved quite adequate for the organization of the large as well as the small conferences. Tea each afternoon in the graceful lounge of the nurses' residence provided an opportunity for sociability and a pleasant ending to a busy day.

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Book Reviews

A General History of Nursing, by Lucy Ridgely Seymer, M.A. (Oxon.), S.R.N. 332 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 2nd Ed. 1949. Illustrated. Price $4.25.

Reviewed by Elsie J. Wilson, Central Tuberculosis Registry, Winnipeg, Man.

This reader found this history extremely interesting. We watch modern nursing evolve through the ages in country after country but without any feeling of being hurried along.

As we read, we realize how many of our difficulties are caused by legacies left us by those who went before. The mistakes we are making now and our short-sighted plans will, in their turn, remain to plague those who come after us. It behooves us to read our history carefully, both to follow wise guidance from the past which we have been ignoring and to avoid making mistakes of our own.

The book first deals with the life of the early Mediterranean countries, then with the Deaconess Movement and the role of the early Christian Church in the care of the sick. We are shown the part played by both secular and religious organizations, by both men and women nurses, and we see the growth from the visiting of the sick poor to present day public health nursing service. The development of nursing education, nursing organization, and professional journals is ably presented.

Throughout, we are impressed with the unevenness of progress in nursing in different countries. In some, even today, there has been little advance since the early ages.

Sources of information are given throughout. There is a list of professional journals and a lengthy bibliography which includes a list of books on English and European history useful for those wishing to get a general background of social conditions for their study of nursing.

In addition, the book itself is admirable, not too large or heavy. The paper is off-white, roughish texture and without any shine to bother the eyes. The print though small is extremely clear. Altogether this is a very satisfactory book.

Epilepsy and Convulsive Disorders in Children, by Edward M. Bridge, M.D. 670 pages. Published by McGraw-Hill Co. of Canada Ltd., 50 York St., Toronto 1. 1949. Illustrated. Price $9.35.

Reviewed by Alice O'Shaughnessy, Teaching Staff, Regina Grey Nuns' Hospital.

The author is well qualified to write such a book after many years devoted to the care

of epileptic children. The material on which the work is based is founded on scientific research carried on by pediatricians, internists, psychiatrists, neurosurgeons, social workers, laboratory technicians, and representatives from community agencies.

In the preface it is stated: "They come to know the patient and families, not as so many 'cases' but as human beings, handicapped by a distressing disease, doing their utmost to find relief from symptoms or a tolerable existence in spite of them."

Throughout the book the author made you feel that each patient was treated as an individual. They not only treated the disease but also tried to help the patient and family to adjust to the problem which arose.

In the discussion of the etiology of epilepsy, Dr. Bridge has not presented it from the point of view of causative agent, but rather of the forces or factors that combine to give rise to the symptoms. He has divided these into: heredity, brain injury, physiological disturbances, personality maladjustments, environmental factors. He points out that heredity is probably of least importance.

The pictorial table of contents before each chapter helps one to appreciate the many problems of an epileptic.

This is a scientific book written for the medical profession but its easily understandable presentation with all its statistical data, its valuable outlines of diagnostic procedures, outlines for clinical study, diets, suggestions for activities and occupation for epileptic persons, would not be beyond the comprehension of student nurses. It certainly would be a great source of information for nurses caring for epileptic children and also for parents of these children.

Nursing—An Art and a Science, by Margaret A. Tracy, R.N., A.B., M.S. and collaborators. Published by the C.V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge Street, Toronto 1. 3rd Ed. 1949. Illustrated. Price $4.40.

Reviewed by Clara Graham, Lecturer in Nursing, McMaster University, Hamilton.

The selection of the title "Nursing—An Art and a Science" indicates the clarity of purpose with which Miss Tracy meets the challenging problem of preparing a textbook of basic nursing for the instructors' and the students' use that will meet the prerequisites stated in the following quotation from the preface: "Nursing is never static. While the fundamental principle of consideration for the welfare of the patient never changes, methods of insuring this are constantly being improved with new discoveries in medical science and new devices for carrying out the procedures indicated. Along with this has come a better understanding on the part of nurses of their own functions and place in the total health picture."

What procedures are new? How has nursing changed? What are the nurse's functions in society today? These and other questions are answered. The nursing procedures and treatments have been carefully selected and succinctly presented. The first two chapters attempt to define nursing—its scope, functions, and responsibilities—and to point up the changes needed in the basic nurse's education, in both the academic and clinical field, to prepare her to meet the demands of modern society.

The division of the book into three parts makes for quick reference. Part I deals chiefly with the care of the patient and his environment; Part II with diagnostic procedures; Part III with nursing procedures and therapeutic treatments.

Some of the outstanding features of the book are: the constant emphasis on meeting the patient's emotional as well as physical needs; the frequent illustrations of adaptation of procedures to home situations; the many excellent illustrations and diagrams; the section on miscellaneous information; the sample "Guide Sheet for the Study of a Patient"; and the fact that procedures, treatments, and techniques are discussed in terms of principles. The latter approach makes for more effective learning for the student and also enhances the value of the book since the principles presented can be enlarged upon and adapted to any local situation.

This timely, concise, clearly written textbook of nursing principles and practices will be a valuable adjunct to any nurse's library—student, graduate, or instructor.

Techniques of Supervision in Public Health Nursing, by Ruth B. Freeman, R.N., B.S., M.A. 466 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1949. Price $5.75.

Reviewed by Katherine M. Weatherhead, Educational Director, Greater Montreal Branch, Victorian Order of Nurses.

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Miss Freeman's new edition of "Supervision in Public Health Nursing" was very much needed so that it might be continually useful as a resource book to administrators, supervisors, and staff nurses in the public health field. The chapters, with the exception of Building Understanding, remain the same in name but in some instances have been almost completely rewritten to keep pace with our times.

Of real help to supervisors will be the chapter entitled: What is Supervision? It has doubled in length and goes into some detail to describe and give examples of approaches to supervision in general use in the public health field today. These are:

1. Technical vs. creative supervision.
2. Cooperative vs. authoritarian supervision.
3. Scientific vs. intuitive supervision. One cannot but recognize familiar situations and become more aware of pitfalls to be avoided in the area of supervision.

The amount of space devoted to the very important subject of group experience was limited. The inference of the two paragraphs was that "experience in teaching adds much to the nurse's skill." Miss Freeman goes on to suggest that if it is not possible to arrange for such experience within the agency, it would be well to seek the experience outside — for example, Red Cross home nursing classes, parents' study groups, etc. Some of us were hoping for more help in this area.

The unchanged portions of the text continue to be a real strength to the new supervisor and good reference for supervisors who like to review techniques periodically.

The suggested readings at the end of each chapter, for the most part, contain many new references and in some instances the newer edition of the previous suggested reference.

This book should be a "must" in every public health agency office.

Surgery for Nurses — A Textbook for the Surgical Nurse, by James Kemble, Ch M., F.R.C.S. (Eng.), F.R.C.S. (Edin.). 348 pages. Published by John Wright & Sons Ltd., Bristol, Eng. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. Illustrated. 1949. Price $5.25.

Reviewed by Margery Edgar, Clinical Instructor in Surgery, Royal Alexandra Hospital, Edmonton.

In his introduction the author states: "The surgeon in his lectures to nurses must attempt to define the extent of the knowledge which he considers adequate to enable the nurse to do her work with intelligence and with understanding. He should impart sufficient of the subject but no more than sufficient." The author has attained his objective by giving nurses the principles of surgery in a concise, convincing, and forceable style with maximum clarity and a minimum of detail. The latter feature impresses one with the feeling that the book, because of its brevity, could almost in some instances be classed as a reference book of technical surgery for the nurses. "If she wishes to have more specialized information upon some particular case of disease for which she is caring, then the place for her to seek it is in a standard textbook of surgery." On the other hand, practically every subject introduced is clearly illustrated with excellent large drawings and photographs, many of which are in color.

The material in the book is attractively and well organized. Part II, Surgical Technique, is dealt with in an especially simple and instructive manner for the student nurse. Included in this section are aseptic technique, sterilization, preparation of the patient for operation and pre-operative treatment. The operating theatre: construction, furniture and equipment, anesthesia, the operation, post-operative care and the complications after operations. The illustrations here of instrument collections and arrangements for the different types of operations are most valuable.

"A nurse's duty is nursing and a surgeon's duty is surgery but the nurse and the surgeon are colleagues mutually assisting one another in treating the patient." With this thought in mind the author has included some material really in the realm of surgical nursing, but only enough to help the nurse understand her duties in specific cases and what is expected of her by the surgeon. It is essentially a textbook dealing with principles of surgery for nurses and is not a surgical nursing text. It is based upon lectures given by the author to nurses over a period of years and, while written for English nurses, with the exception of a few differences in spelling and expressions, is applicable to Canada.

Because of its completeness, clarity, and brevity it should prove to be a valuable time-saver for surgeons, called upon to

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lecture to nurses, in selecting and determining the lecture content.

The Premature Infant — Medical and Nursing Care, by Julius H. Hess, M.D. and Evelyn C. Lundeen, R.N. 381 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 2nd Ed. 1949. Illustrated. Price $7.50.

Reviewed by Marie Sorenson, former Head Nurse, Vancouver General Hospital.

This second edition of a book, which has been accepted as a sound text on the medical and nursing care of the premature infant, presents the latest developments in the relationships of that care to the degree of prematurity of the infant. It is a study of the premature infant — its physiology, growth and development, complete with details and problems of disease conditions, medical and nursing care.

Latest material on therapeutic measures, special equipment, and supportive treatments necessary for the management of the premature infant is discussed in detail. Ideal hospital conditions are described. Home care requirements and improvisations are suggested. Feeding and feeding techniques are emphasized by careful diagrams and full recognition is given to the importance of all nursing care aspects. Routine procedures are discussed as minutely as in a nursing arts textbook — bathing and diapering, formula room routine, the collection of breast milk by manual expression, intravenous infusions and blood transfusion are described and illustrated so clearly that the most junior nurse would understand them.

New material is presented also on pathologic diseases and infections of the eyes and the skin, the anemias and other blood dyscrasias, including a chapter on the Rh factor, congenital syphilis, and meningitides. Recent information on the therapeutic use of the sulfonamides and antibiotic agents is given.

Statistics and specific data relate almost entirely to the premature infant station of the Michael Reese Hospital in Chicago but the conclusions are applicable anywhere. The outline of city and state plans for the care of premature infants and the analysis of minimum requirements for nurseries for premature infants can be adapted and utilized by any community or hospital unit. The suggested teaching outline for classes on nursing of premature infants might well become a teaching aid for the nursery supervisor.

This is a detailed, specific study of every phase of the care of the premature infant, yet it is presented in such a logical, concise manner that it recommends itself as a guide and reference text to all concerned with this branch of pediatrics.

Ontario

The following are recent staff changes in the Ontario Public Health Nursing Service:

Hilda Pennock has retired after a long period of service with the Ontario Department of Health. She held the positions of staff nurse, supervisor, and for the past four years assistant to the director of the Division of Public Health Nursing. Miss Pennock was a member of the class in the first course in administration and supervision in public health nursing offered by the McGill School for Graduate Nurses in 1942.

Appointments: *Lillian Coles* (Ont. Hosp., Whitby, and University of Toronto general course) to Guelph board of health; *Muriel Rice* (Lady Minto Hosp., New Liskeard, and University of Western Ont. certificate course) to Haileybury.

Resignations: *Margaret Jewell* from Brant County health unit; *Dorothy (Morgan) Lang* from Etobicoke Township.

News Notes

BRITISH COLUMBIA

ABBOTSFORD

Mrs. B. Clarkson's home was the scene of a recent meeting of the Matsqui-Sumas-Abbotsford Chapter when 18 members were present. A report was given by the Ways and Means Committee on the sale of tickets for the pedal car which is to be on display in the bowling alley. Arrangements are underway for the Fall Tea, scheduled for September. Members were invited to attend the regional meeting in Mission. Mrs. F. Lillies was chosen as delegate to attend the Emergency Flood meeting. E. Towlan gave some highlights of the R.N.A.B.C. convention which she attended as chapter representative. An educational trip through the Essondale Mental Hospital was planned by the members.

HANEY

Mrs. Lois A. Phillips, of Haney, is now serving as secretary of the Maple Ridge-Pitt Meadows Chapter, replacing Mrs. E. Sleath.

PORT ALBERNI

In May, the Alberni Valley Chapter were hostesses to the Vancouver Island District when they held their annual meeting, with Sr. M. Claire presiding. Eighty-six nurses signed the register. The representatives were

welcomed by the local president, Mrs. L. Caldwell. The five Island chapters were represented and gave reports as follows: Victoria, Mrs. C. Macleod; Cowichan-Newcastle, E. Stewart; Nanaimo, J. Pearson; Alberni Valley, Mrs. Caldwell; Plateau, Mrs. V. Tams.

The members heard reports on the R.N.A.B.C. annual meeting as follows: District official delegate, Mrs. D. B. Quayle; resolutions, Mrs. Macleod; legislation, K. Bailey; nursing education, Sr. M. Claire; cancer nursing, J. Kent; public health institute, Miss Fairbanks.

The election of officers was as follows: President, Sr. M. Claire; vice-president, Mrs. Rowan; secretary-treasurer, Mrs. C. Macleod. Councillors, Sr. M. Claire, Mrs. F. MacDonald, Victoria; K. Bailey, Alberni Valley. Mrs. Quayle is *Canadian Nurse* representative.

The fall district meeting will be held in the Plateau area.

Charnell Studios, Port Alberni, B.C.

Back row—Chapter Presidents: E. STEWART, *Cowichan-Newcastle;* MRS. C. MACLEOD, *Victoria;* J. PEARSON, *Nanaimo;* MRS. L. CALDWELL, *Alberni Valley;* MRS. V. TAMS, *Plateau. District Vice-President,* MRS. F. ROWAN. *In front—President,* SR. M. CLAIRE and *Secretary-Treasurer,* MRS. D. B. QUAYLE.

KELOWNA

Olive Garrood, of Kamloops, was guest speaker at a recent meeting of Kelowna Chapter. Following a colorful description of her journey to New Zealand and Australia, Miss Garrood spoke on the nursing conditions and public health services in the sister Dominions.

E. Stocker, Bursary Committee chairman, presented for consideration three amendments to the bursary regulations. These were as follows: (1) Two hundred dollars be awarded annually instead of half the chapter's cash balance at the end of the fiscal year. (2) Applications be submitted for consideration prior to the January meeting each year, commencing in 1951. (3) The accepted applicant shall show evidence by May 1 that she will use the bursary in the year it is awarded or withdraw her name in favor of another applicant. After some discussion, these amendments were adopted.

Mrs. R. McKenzie, representative to the

Public Health Auxiliary, reported that the preschool clinics had been started. H. Empey read a report from the Local Council of Women. The chapter voted to support the council in their endeavor to establish a central clothing depot for charitable needs. Mrs. J. Kinnear reported on the arrangements for the annual dance. Mrs. McKenzie and M. Davies represented the chapter at a meeting regarding the proposed establishment of a Community Chest. Mrs. M. Smith held the winning ticket for the uniform raffle, the proceeds to help defray printing expenses incurred by the chapter for the R.N.A.B.C. annual meeting.

It was decided to bear the additional expense for overseas parcels now that Can-aid parcels have been discontinued. Two letters from recent recipients were read, revealing their deep appreciation and continuing need. A parcel is sent monthly to British nurses.

Miss Davies recently addressed the Kelowna High School Girls' Hi-Y on "Nursing—A Career for Young Women."

Gwen (Almond) Finlayson is now on the General Hospital staff. Anne Engelman was awarded the General Proficiency Medal at the graduation exercises of the Royal Inland Hospital, Kamloops.

MANITOBA

BRANDON

Some 45 nurses, both graduates and students, attended the National Nurses' Rededication Service at St. Matthew's pro-Cathedral held in May. Rev. F. G. Ongley delivered an inspiring sermon, stating that nursing was a noble profession and, as Christ had done before, they were, too, in some small way, following in the Great Physician's footsteps.

The Brandon Flying Club was the scene of the annual dinner of the Association of Graduate Nurses when 22 graduates of the Mental and General hospitals were honored guests. Each graduate was presented with her first year's membership to the association, in the form of a small scroll. The toast to the King was proposed by Mrs. E. Griffin and that to the graduates by Mrs. G. Hotson, Miss Thompson responding. Jean Higgens contributed two vocal numbers. The guest speaker was Mrs. W. Dinsdale whose interesting address revealed how social work and nursing have many similarities.

The president, Mrs. Griffin, presided at the short business meeting. The announcement of Neepawa having its own association of graduate nurses was received with pleasure. Mrs. R. Kent gave a report on the M.A.R.N. annual meeting, stating that recruitment of nurses was being strongly emphasized. L. Booth gave the annual report and Mrs. P. Dick that of the treasurer. Mrs. F. Durnin presented the report of the Nominating Committee as follows:

President, Mrs. E. Griffin; vice-president, Mrs. G. Hotson; secretary, L. Booth; treasurer, J. Markey. Committee conveners: Social, Mrs. A. Wiley; scholarship, E. Cranna; visiting, Mrs. L. Mathie; married nurses

group, Mrs. D. Speakman; cancer group, Mmes S. Lewis, D. Johnson. Representatives to: Press, Mrs. M. McNee; *The Canadian Nurse*, B. Daniels.

F. McCausland extended a vote of appreciation to the retiring executive and Mrs. E. Griffin gave a vote of thanks to Mrs. R. Brown who was convener for the dinner.

General Hospital

Twelve members of the Class of 1953A recently were "capped" at a ceremony held at St. Mary's Anglican Church. D. Wisdahl contributed the prelude while the invocation was given by Canon H. L. Newton. The students were capped by Marjorie Jackson, superintendent of nurses, while M. Thompson, president of the Student Nurses' Association, welcomed them into that group. M. Chapple gave the response.

I. Zeigler was entertained at the home of J. Higgens by friends, prior to her departure from the staff to join the R.C.A.F. at Rockcliffe, Ont.

NEW BRUNSWICK

Saint John

General Hospital

The alumnae association recently held its 62nd graduation dinner when the members of the 1950 class were special guests. L. Peters, B. Selfridge, and A. Carney formed the reception committee. Dancing followed the dinner.

Twenty members of the graduation class, who completed their R.N. exams, held a banquet following their final paper.

St. Joseph's Hospital

Plans were made at a recent meeting by the alumnae for the annual dinner and dance in honor of the 1950 graduation class. M. McDonald was named convener for this event. The president, M. Wallace, was in charge of this meeting.

ONTARIO

Districts 2 and 3

Brantford

About 85 nurses from Brantford and district, mostly in uniform, presented an impressive spectacle when they met in St. Jude's Anglican Church to celebrate the National Nurses' Re-dedication Service. Rev. F. W. Schaffter addressed the group, speaking on the work of nurses from the time of the South African War until the present day. The ushers were D. Armstrong, G. Anderson, M. Gillin, and M. Patterson. B. Mitten sang a solo and a trio, composed of M. Winter, O. Stone, and R. Wood, sang a selection. Many nurses were members of the choir which sang a beautiful anthem.

At a recent meeting of the General Hospital Alumnae Association plans were made for the annual banquet and dance to be given in honor of the class of 1950. N. Golden was appointed general convener. Alice Riddle,

who attended the R.N.A.O. convention in Toronto, gave an interesting report on provincial association developments.

District 6

Peterborough

St. Joseph's Hospital

Conferring of awards on graduates and students of the school of nursing was an important part of the recent commencement exercises. Sr. M. Agnes was congratulated on having won the $500 medical staff scholarship and the honor of presenting it came to Dr. W. S. Fitzpatrick. It was mentioned that G. Crough and T. Garvey had also been considered for this award. Dr. R. J. Young's medal for bedside nursing was won by Miss Crough. Through the generosity of Mr. and Mrs. L. S. Ryan of Ottawa, a medal and prizes, amounting to $200, were offered the students. In their absence at the ceremony, Dr. C. F. Cahill made the following presentations: Medal for surgical nursing, J. Andrews; $25 for highest standing in theory, T. Garvey; $25 for proficiency in medical nursing, M. Keenan; $25 for proficiency in obstetrical nursing, I. Howard.

For general proficiency in the first year $50 is offered by the Ryans and it was won by B. Schiarrizza. They further offered a $50 first prize for bedside nursing, won by M. Costello, and a second prize of $25 won by M. Tunney. These were presented by Dr. D. Whyte.

Benefaciendo medals, given to three students in each year who stand well in examinations and show interest and kindness to their patients, were presented by the donor, Monsignor F. J. O'Sullivan. If a student is winner of a medal each year, it becomes her property on graduation and is engraved with her name. Those receiving medals were: Graduates, T. Garvey, G. Crough, H. McDonald; 2nd year students, M. Weir, R. Leveque, P. LaForce; 1st year students, M. Lamey, B. Fanning, P. Jackson.

Most Rev. Gerald Berry, Bishop of Peterborough, made the presentation of diplomas and medals to the graduates.

District 8

Cornwall

Proposal to hold a refresher course in the autumn was discussed at a meeting of Cornwall Community Nursing Registry held at Hôtel-Dieu Hospital. While plans were tentative, considerable progress was made to arrange for the event which it is hoped will be a joint educational project between the Cornwall Chapter and the nursing registry. At the course the public relations aspect will be stressed during the three days it is in session. Sybil Everitt, local V.O.N. supervisor, will be chairman.

Evelyn Paul, president, was in the chair at this meeting when the secretary's report was given by Rev. Sr. Mooney. Plans for the annual tag day on September 16 were made.

QUEBEC

MONTREAL

Hôtel-Dieu

Le 17 mai les infirmières de Montréal se réunissaient ici pour la 30ième année afin de fêter Jeanne-Mance, première infirmière canadienne. Tous les hôpitaux avaient délégués des infirmières pour déposer des fleurs au pied du monument de la cour d'honneur de l'Hôtel-Dieu. Cette cérémonie était suivie d'une conférence par Mlle Marie-Claire Daveluy qui parla de ses récentes recherches en France, surtout à Langres, patrie de Jeanne-Mance.

Mlle Suzanne Langevin, qui vient de terminer le cours post-gradué en neurologie et neurochirurgie à l'Institut Neurologique de Montréal, prêtait son concours à la démonstration organisée par cet institut et qui était présentée au congrès biennal de l'A.I.C. à Vancouver.

Royal Victoria Hospital

The increasing number of young graduates joining the association and, therefore, becoming eligible for its sick benefits was noted by Mrs. F. A. C. Scrimger, president, at the recent annual meeting of the alumnae association. The president also noted an active and stimulating year. She spoke with regret of the resignation of Fanny Munroe as superintendent of nurses and added that the hospital had been fortunate in securing the services of Helene Lamont to succeed her.

Other reports were given by the secretary-treasurer, recording secretary, and by the chairmen of the finance, private duty, library, visiting, *Canadian Nurse*, war memorial, and program committees, as well as by the representatives to the Montreal Council of Women.

Janet MacKay was elected president. Other officers include: Vice-presidents, Mrs. C. Sutherland, H. Lamont; secretary, J. Cook. Directors, Mmes Scrimger, M. Morrell, Misses M. Warnock, E. Gordon, E. Turnbull, E. Currie, and A. Haggart.

The following 1950 graduates are serving on the staff as follows: M. Clark, assistant head nurse, Ward E, women's surgery; B. Miller, assistant, Ward N, pediatrics; G. Nicholl, assistant, Ward L, urology.

SASKATCHEWAN

CANORA

Mrs. E. Gravert, of Graigmont, Idaho, has been appointed superintendent of nurses at the Union Hospital. She is a graduate of the Royal Alexandra Hospital, Edmonton.

REGINA

General Hospital

"The girls get together to sing for an hour once a week because they like it," said Mr. N. Langdale, introducing the Nurses' Glee Club at Carmichael Church at a recent concert. Many old favorites were included in the selections. Assisting artists were Mr. L. Schnell, violinist, and Mr. W. Pengelly, pianist. Jean MacKay was accompanist for

the choir and June Stinson accompanied Mr. Schnell. Patrons included: Mayor G. N. Menzies and Mrs. Menzies; Dr. H. E. Baird and Mrs. Baird; Alderman J. Wilkie and Mrs. Wilkie; Dr. D. E. Rodger and Mrs. Rodger, and Miss M. E. Thompson.

During the intermission, Mr. Ian Barrie spoke briefly on the work of the Canadian Arthritis and Rheumatism Society and a film—"Conquer the Cripple"—was shown.

In introducing the glee club, Mr. Langdale briefly outlined its history. It began in November, 1948, when the nurses organized and asked him to assist them in improving their singing of Christmas carols for the patients. The club entered the Rotary Christmas Carol Festival that year and again in 1949.

Proceeds of the concert were in aid of the Canadian Arthritis and Rheumatism Society.

Seventy-one students received their diplomas at the 1950 graduation exercises of the school of nursing. The prize winners were as follows: L. Swanick, Florence Nightingale prize for devotion to duty; M. Fraser, Dr. David Low Memorial Medal for general proficiency and obstetrical nursing prize; I. Colvin, medical and pediatric nursing prizes; S. Collins, surgical nursing; M. Clark, Dr. Roger Memorial Medal for first aid. J. Wallin gave the valedictory address.

The Board of Governors of the hospital entertained the 1950 class at a formal dance.

The 4th and 5th floors of the new wing, the obstetrical unit, are now open and the official opening of the cerebral palsy clinic took place in April.

M. Humphreys has resigned from the staff to be married.

Grey Nuns' Hospital

Sixty-eight nurses received their diplomas from Lieut. Gov. J. M. Uhrich at the graduation exercises. Dr. G. M. Malone presided at the ceremony and the Hon. T. C. Douglas, Premier of Saskatchewan, was the special speaker. Mayor G. Menzies, assisted by Mrs. H. Ross, alumnae president, presented the special prizes and awards.

Social functions favoring the 1950 class included: A formal dance sponsored by the 1951 class; a tea and reception given by the Sisters. On graduation day the class attended Holy Mass celebrated by Archbishop M. C. O'Neill. Preceding this, His Grace presented the graduates with the school pin. Breakfast was afterwards served in the hospital dining-room.

Preliminary class project

The preliminary class of the school of nursing participated in a History of Nursing project given at two sessions. The lecture room was set up with displays of important figures in the history of nursing and medicine, including three sections devoted to Florence Nightingale, Jeanne Mance, and Mère d'Youville. Talks were given by members of the preliminary class and films were shown. Sr. A. Levasseur and M. Crawford were in charge of preparation for this project.

History of Nursing project

SASKATOON

City Hospital

At the convocation exercises of the University of Saskatchewan five graduates from the school of nursing received their degrees. Merle Menzies, of Morden, Man., received the University Scholarship in Nursing and achieved her degree with distinction.

Graduates and students commemorated Florence Nightingale Sunday by a church parade in uniform to 3rd Ave. United Church.

St. Paul's Hospital

The 2nd-year student nurses gave a banquet and dance in honor of the graduation class in the auditorium, transformed for the occasion into an "old world garden." Classes 2B and 1A followed a tradition by entertaining at tea for the graduates and their mothers. May 14th began with Mass for the 64 new graduates in the hospital chapel, followed by a special breakfast, and ending with the final exercises at the Capitol Theatre.

Saskatoon Sanatorium

Sylvia Reekie attended the graduation exercises of Holy Family Hospital, Prince Albert, when she was the recipient of the award for obstetrical nursing.

Ruby Walper has been appointed instructor. Other new staff members include: Laura Wilson, formerly superintendent of nurses at Shell Brook, Sask.; Agnes (Scrimshaw) Statham. M. Baraniecki has returned to Ontario.

Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Supt. of Nurses for 320-bed Sanatorium for Tuberculosis. Apply, giving qualifications, references, salary expected, etc., Medical Supt., Fort William Sanatorium, Fort William, Ont.

Director of Education with teaching experience. Degree not necessary. Salary: $185-240. **Operating-Room Supervisor.** Preference to applicants with post-graduate training. Salary: $185-215. 160-bed hospital. 55 students. 4 wks. holiday & 3 wks. sick time with pay each yr. Superannuation scheme. Apply Mrs. J. S. Harry, Supt. of Nurses, Victoria Hospital, Prince Albert, Sask.

Clinical Instructor in Surgical Nursing for School of Nursing, General Hospital, Regina, Sask. Duties to commence not later than Sept. 5. Salary open. Apply, stating qualifications & experience, to Supt. of Nurses.

Science Instructor not later than Sept. 1 for 150-bed hospital. 70 students. Apply, stating age, qualifications, experience & religion, Director of Nursing, Public General Hospital, Chatham, Ont.

Operating-Room Supervisor immediately. **Instructor** (qualified) & **Medical & Surgical Supervisor** (experienced) for Sept. 1. 95-bed hospital. Apply, stating qualifications, etc., Supt., Victoria Hospital, Renfrew, Ont.

Public Health Nurse for City of Owen Sound. Salary: $2,000-2,400 according to experience plus car allowance. Apply M. S. Leslie, Board of Health, City Hall, Owen Sound, Ont.

General Staff Nurse for permanent position. Salary: $175 per mo.; additional $7.50 after 1 yr. 48-hr. wk. 4 wks. holiday with pay. Live in—$40 per mo. for room, board, laundry. Apply Box 366, General Hospital, Cumberland, B.C.

General Duty Nurse for small Community Hospital, West Coast, Vancouver Island, B.C. Salary: $175 per mo. less $30 maintenance. 8-hr. duty, 44-hr. wk. 2 wks. holiday with pay after 6 mos. or 4 wks. after 12 mos. Write Supt., General Hospital, Tofino, B.C.

Are you contemplating a change?—meeting new people, seeing new scenery, working in a new environment? Apply Supt. of Nurses, Langley Memorial Hospital, Murrayville, B.C.

Asst. Supt. Also **Night Supervisor** for small hospital near Toronto. Apply, stating age, experience, school & date of graduation, c/o Box 3, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Nursing Arts Instructor, Educational Director, Clinical Instructor immediately. The hospital, located in capital city, is connected with large clinic & college which aids greatly in teaching students. Apply Director of Nurses, Bismarck Hospital, 6th & Thayer, Bismarck, North Dakota.

Nursing Arts Instructor & Science Instructor for Nursing School, Holy Family Hospital, Prince Albert, Sask. Submit statement re qualifications & salary expected to Director of Nursing.

Instructor of Nurses. New hospital to be started this Summer. List qualifications & experience in 1st letter. Apply Supt., Chipman Memorial Hospital, St. Stephen, N.B.

QUALIFIED NURSING INSTRUCTRESS POSITION AVAILABLE

Applications will be received by the undersigned for a position of ***Instructress of Nurses*** at **The Nova Scotia Sanatorium,** a 400-bed institution, operated by the Department of Public Health for the treatment of Tuberculosis. Both an affiliate student and a post-graduate teaching program have been underway for some two years. Applicants must be qualified for registration in Nova Scotia and have had post-graduate training.

Those interested may obtain further information by writing to:
The Superintendent of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

The Province of Manitoba Requires

SENIOR INSTRUCTOR OF NURSING

for the Hospital for Mental Diseases, Selkirk, Manitoba

Must be Registered Nurse, preferably with Mental Nursing certificate, capable of supervising educational program for undergraduate and graduate nurses, under direction of Superintendent of Nurses.

Salary Schedule: $2,340 to $2,940 per annum, less $300 per annum for full maintenance and laundry. Regular annual increases, liberal sick leave with pay, 4 weeks' vacation with pay annually, pension plan, etc. Apply at once to:

MANITOBA CIVIL SERVICE COMMISSION
247 LEGISLATIVE BLDG., WINNIPEG

Clinical Instructor for Surgical Nursing, preferably with experience, by Sept. 1. 500-bed hospital. Salary: $195-225 (bonus for degree). Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Public Health Nurse for generalized service in urban municipality. Salary: $1,800-2,300 according to experience. Apply, in writing, stating qualifications, experience, age, etc., Medical Officer of Health, Dept. of Health, Kingston, Ont.

Public Health Nurses for Staff positions. Voluntary agency specializing in Tuberculosis Clinic & Home Visiting Services. Apply Supervisor, Public Health Dept., Royal Edward Laurentian Hospital, 3674 St. Urbain St., Montreal 18, Que.

District Nurses for Province of Alberta. Rural service. Emergency treatment, preventive & maternity program. Furnished cottage, fuel, water supplied. Salary schedule: $1,920-2,400. Sick leave, annual vacation, pension. Present Cost of Living Bonus — $21 per mo. Apply A/Director, Nursing Division, Dept. of Public Health, Edmonton, Alta.

Registered Nurse for charge of Central Supply Room. 140-bed hospital. Also **General Duty Nurses for Operating-Room & Wards.** 48-hr. wk. 3 wks. vacation. Blue Cross plan. Apply Acting Director of Nurses, Women's College Hospital, Toronto 5, Ont.

Graduates with Operating-Room experience for duty in modern, well-equipped Operating-Room Dept. Gross salary: $38-44 per wk. Opportunities for advancement to Staff positions for qualified graduates. Apply C. E. Brewster, Supt. of Nurses, General Hospital, Hamilton, Ont.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross salary: $38-44 per wk. 88-hr. fortnight. Hospitalization & medical benefits if ill. Apply C. E. Brewster, Supt. of Nurses.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

CANADIAN RED CROSS SOCIETY

invites applications for ***Administrative*** and ***Staff*** positions in **Hospital, Public Health Nursing Services,** and **Blood Transfusion Service** for various parts of Canada.

THE GREATEST NEED FOR OUTPOST NURSES IS IN THE PROVINCE OF NEW BRUNSWICK — BOTH AT MATRON AND STAFF LEVEL.

- Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

For further particulars apply:
National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ontario.

• DIRECTOR OF NURSES •

required for

WOODSTOCK GENERAL HOSPITAL

100 beds and Training School

Apply
F. Longhurst, Administrator, General Hospital, Woodstock, Ontario

Staff Nurses, eligible for registration in Michigan, for all services in modern 200-bed hospital. Salary: $216 per mo. for 44-hr. wk. 6 mos. increase. $10 extra for 3-11 & 11-7 duty. 7 paid holidays. 2 wks. vacation & 12 days sick leave per yr. Cafeteria meal service. Laundry furnished. Apply Director of Nurses, General Hospital, Pontiac 18, Michigan.

Graduate Dietitian at Ontario Hospitals in Kingston, Whitby, Woodstock. Initial salary: $2,140 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. at above hospitals.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock. Initial salary: $1,840 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. of Nurses at above hospitals.

Registered Nurses for General Duty required for University of Alberta Hospital, Edmonton. (640 beds). Gross salary: $170 per mo. 1st year, $180 2nd year and $190 3rd year of service in hospital. $25 per mo. deducted for meals and laundry. Statutory holidays. Sick leave: 3 weeks after 1 yr. service, with annual increase of 1 wk. to a maximum of 13 wks. Blue Cross coverage on a 50% employee contributory basis. 1st class railway fare to Edmonton refunded after 1 year continuous service. Pleasant university environment. Apply Supt. of Nursing Services.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $115 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end ea. mo. 1 mo. annual vacation. 14 days sick leave. Apply Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

General Duty Nurses for modern, well-equipped hospital in picturesque Lakehead. 48-hr. wk. Cumulative sick leave. 1 mo. vacation after 1 yr. service. Gross salary per mo.: $170 less $20 for meals & laundry. $45 deducted if living in residence. Annual increment. Railway fare up to $50 with 1 yr. contract. Also **O.R. Supervisor** with post-graduate experience. State qualifications & salary expected. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

Infirmières demandées par

LA SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE

- Service général dans les avant-postes hospitaliers.
- Postes d'infirmières surveillantes et infirmières visiteuses dans les avant-postes infirmiers.
- Service de Transfusion.

Les infirmières, possédant un diplôme reconnu par l'Association des Infirmières du Canada, devront faire parvenir leur demande d'emploi à l'adresse suivante:

Directrice Nationale, Services du Nursing,
La Société Canadienne de la Croix-Rouge,
95 rue Wellesley, Toronto 5, Ontario, Canada

Maternity Nurses—post-graduate training preferred, not required. 48-hr. wk.; straight shift. New Maternity Pavilion opening in near future. Information concerning salaries, sick time, etc., provided after application has been received, giving qualifications, years of experience, etc. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

General Duty Nurses. 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

General Duty Nurses for 400-bed hospital. New Wing just opening. 8-hr. day, 44-hr. wk. 10 statutory holidays. B.C. registration required. Salary: $175 basic. Credit for past experience. Annual increments. Vacation: 28 days after 1 yr. Sick leave: 1½ days per mo. cumulative. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Graduate Nurses for General Floor Duty. Salary: $115 per mo. Full maintenance & laundry. $60 yearly increase up to 3 yrs. Apply, stating qualifications, Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, Que.

Vancouver General Hospital requires **General Staff Nurses.** Salary: $177 per mo. increasing to $207. **Clinical Instructor** — for Surgical Nursing, preferably with experience in General Surgery & Urological Nursing. Salary: $207-232. **Instructor** — preferably with degree as chief subject will be Bacteriology. **Instructor** — preferably with previous experience in teaching & with ward experience. Duties include lectures & demonstrations in nursing arts & allied subjects. Salary: $197-222. Perquisites include: 44-hr. wk. (week-ends free); statutory holidays — 11; vacation — 28 days; sick leave — 1½ days per mo. cumulative; pension plan (if under age 35). Apply Director of Nursing, General Hospital, Vancouver, B.C.

Graduate Nurses for completely modern West Coast hospital. Commencing salary: $185 per mo. less $40 for board, residence, laundry. Special bonus of $10 per mo. for night duty. $10 annual increment. 44-hr. wk. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. accumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Registered Nurses for General Staff Duty on Rotation Service. Apply, Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

General Duty Nurses for 60-bed hospital. Salary: $140 per mo. plus full maintenance to Registered Nurses; others in accordance with qualifications. Apply Supt. of Nurses, Lady Minto Hospital, Cochrane, Ont.

Graduate Nurses (2) by Sept. 1 for new modern 20-bed hospital. Salary: $150 per mo. & full maintenance. 8-hr. day, 6-day wk. 2 wks. with pay end of yr. Lively community near U.S. border. English-speaking population. Good climate. Apply P. J. Rasmussen, Sec., Community Hospital, Climax, Sask.

Graduate Nurse for 10-bed hospital. Salary: $150 per mo. plus full maintenance. 1 mo. holiday with pay after 1 yr. Modern nurses' residence apart from hospital. Duties to commence as soon as possible. Apply Matron, Frontier Hospital, Frontier, Sask.

Public Health Nurses immediately for the Greater Montreal Branch of the Victorian Order of Nurses. Interesting program of nursing care & health counselling in homes. Stimulating staff education program. 5-day wk. 4 wks. vacation. Initial salary: $2,160. Apply District Supt., V.O.N., 1246 Bishop St., Montreal 25, Que.

General Duty Nurses—Medical, Surgical, Pediatrics, Psychiatry, Tuberculosis. Beginning salary: $231 with $10 differential for Pediatrics, Psychiatry, Tuberculosis; also, Evening & Night. 600-bed hospital with school. 40-hr. wk. 8 paid holidays. 3 wks. vacation. Laundry. Accumulative sick leave. Apply Director, Nursing Service, General Hospital, Fresno, California.

General Duty Nurses for 50-bed hospital. 8-hr. day, 6-day wk. 4 wks. vacation with pay after 1 yr. service. Salary: $145 per mo. with full maintenance. Apply Ruby W. Ganton, Matron, Union Hospital, Rosetown, Sask.

General Duty Nurses for new, small hospital in San Joaquin Valley, California. Hospital is well equipped & town offers all the advantages & pleasantness of life in small community within easy travel distance of Oakland & San Francisco. 40-hr. wk. Minimum starting salary: $220. Write Administrator, Community Memorial Hospital, Tracy, California.

Graduate Nurse for rapidly expanding hospital. Excellent prospects. Good wages. Room & board. Blue Cross. Apply Dr. A. R. Penn, 7745 Sherbrooke St. E., Montreal 5, Que. (*Phone* CLairval 2847)

Nursing Arts Instructor for August in School connected with 300-bed hospital. 44-hr. wk. **Registered Nurses for General Duty.** 48-hr. wk. Apply Supt. of Nurses, Misericordia Hospital, Edmonton, Alta.

Registered Nurse (Protestant) for Aug. 1. Interested in babies—to take charge of nurseries at Protestant Children's Village, Ottawa. 6-day wk. 3 wks. annual holiday. Full maintenance. *Phone* 8-1626 for appointment or write, stating age, salary expected & experience, Supt., Protestant Children's Village, Ottawa, Ont.

The New Three Way Chronic Convalescent Hospital, Rimbey, Alta., requires **2 Graduate Nurses for General Duty.** 8 hr. day. Salary: $135 plus full maintenance. Separate nurses' residence. Apply immediately to Matron.

Night Supervisor and Floor Duty Nurses required. Apply with references to Superintendent, Kenora General Hospital, Kenora, Ont.

Prescription for Modern Tensions

Music can relieve tension, reduce fatigue, stimulate appetite, and otherwise affect both the capacity and mental state of an individual, according to findings of James, Lang, Cannon, and other researchers. And music to which one contributes by voice or instrument strongly accelerates the effects. Importance of these principles in developing an adjusted personality is causing more and more psychologists to prescribe music as an essential part of a child's education. It has never been more important than today.

General Duty Nurses required for 20-bed Isolation Hospital.

One nurse for permanent night duty at salary of $200 per month.

Alternate day and night duty at salary of $190 per month.

5½ day week, meals, laundry.

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Balsam Street, Port Arthur, Ont.

Teachers required for Training School 100 beds

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Apply

F. Longhurst, Administrator,
Woodstock General Hospital
Woodstock, Ontario.